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ABSTRACT

In response to a research review indicating that few programs address the father's role in early intervention and preschool programs for the young exceptional child, a three-month practicum was designed which included fathers in physical therapy sessions and in daily home exercise programming for their developmentally disabled children. Practicum goals were to increase fathers': knowledge of early physical development and the importance of and opportunities for father-child interactions; participation in play and caregiving activities with their exceptional children; and responsibility in therapeutic program carryout at home. Implementation involved providing fathers with educational information, rescheduling therapy sessions for fathers' convenience, modeling appropriate physical interactions between children and fathers, and assigning fathers structured exercise programs to implement with their children at home. Of the 14 fathers contacted for participation, 10 attended one therapy session and 9 attended both scheduled sessions. All fathers demonstrated increased knowledge by raising their posttest scores, reporting positive benefits from the experience, and increasing the quality and quantity of interaction time with their exceptional children. Sixty percent of the fathers complied with home exercise tasks and recorded them appropriately. It is recommended that fathers be included in early intervention programs, and that there be frequent contact between the physical therapist and the fathers to ensure continuation of the home program. Appendices include handouts designed for fathers, general guides on early childhood education, instruments for assessing fathers' knowledge and progress, sample responses, and results of interviews with fathers. (Author/CB)

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PRACTICUM REPORT

Center for the
Advancement of Education
Ed.D. Program

Increasing Fathers' Participation In Therapeutic Intervention Programs For Exceptional Children

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Increasing Fathers' Participation In Therapeutic Intervention Programs For Exceptional Children

by

Elizabeth O. Revelj

Cluster XVIII

A Practicum I Report Presented to the Ed.D. Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1985

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Date of Final Approval of Report

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Both the paternal role in early child development and early intervention programs for developmentally disabled young children have elicited increased interest, research and attention the past few years. In reviewing the literature and in surveying early intervention and preschool programs, the author found that few programs addressed the father's role with his exceptional young child. This practicum addressed this problem by including fathers in physical therapy sessions and in daily home exercise programming for their developmentally disabled children.

The practicum goals were: (1) to increase the fathers' knowledge of early physical development and the importance of and opportunities for father-child interactions; (2) to increase fathers' participation in play and caregiving activities with their exceptional children; and (3) to increase fathers' responsibility in exceptional children's therapeutic program carryout at home. Implementation involved giving educational handouts to fathers, rescheduling therapy sessions for fathers' convenience, modeling appropriate physical interactions with the children for fathers, and assigning fathers structured exercise programs to implement with the children at home.

Of the 14 fathers contacted for participation, 10 (71 percent) attended one therapy session and 9 (64 percent) attended both scheduled sessions. All (100 percent) fathers demonstrated increased knowledge by increasing their posttest scores, reported positive benefits from the experience, and increased the quality and quantity of interaction time with their exceptional children. Sixty percent of the participants complied with home exercise tasks and recorded them appropriately.

CHAPTER I

INTRODUCTION

Description of Community, Including Socio-Economic and Geographic Factors

Broward County, located on the southeast coast of Florida, is one of the fastest growing metropolitan areas in the nation, with a current population of 1,200,000. According to 1984 census figures, Fort Lauderdale, with a population of 152,053, is the largest of 28 municipalities within the county and is the seat of the county government, composed of a board of elected county commissioners and a full-time county administrator. Hallandale, a much smaller municipality (37,692 people), is the southernmost city in the county and, like Fort Lauderdale, is self-governing, with an elected commission city manager form of government.

The county is approximately 32 miles long and 40 miles wide with some 165 miles of navigable waterways, ten percent of the total area. Nearly two thirds of the county's western, inland portion is set aside as a natural environment, South Florida Water Management District, and borders Everglades National Park. The area boasts an average year-round

temperature of 75.5 degrees and more than 3000 hours per year of sunshine. This subtropical marine climate draws more than 3 million visitors every year, who contribute substantially to the economic well-being of the county. In addition to tourism, local industry includes interstate banking, international trade, sports, retailing, construction, agriculture, and high-technology. Port Everglades, the deepest seaport south of Norfolk, Virginia, contributes heavily to tourist and industrial revenues as reported by the Chamber of Commerce (1985).

Broward County has adequate medical and educational facilities to meet its needs with 20 general hospitals, at least 8 home health agencies, and the largest fully accredited school system in the country. The school system includes 10 centers for handicapped or special needs students between the ages of 5 and 21 years. Educational programs for younger handicapped children are provided by private schools. There are five private, non-profit agencies in Broward County serving the educational needs of children with disabilities, who are 0 to 5 years old. They are all partially funded by the Florida Department of Health and Rehabilitative Services through money federally mandated by PL 94-142, Education for All Handicapped Children Act of 1975. Two such centers, providing special education for the

0- to 5-year-old population, are the Association for Retarded Citizens and the Ann Storck Center.

Author's Work Setting, Role, and Responsibilities

The author is a licensed physical therapist, who has a small private practice in Broward County, Florida. She has over 27 years of clinical physical therapy experience and 8½ years of teaching experience, which includes both elementary special education classroom assignments and university undergraduate and graduate teaching positions. Academic degrees include a Bachelor of Science degree in physical therapy, a Master of Arts degree in special education, and advanced certification in treatment of neurologically impaired children. As part of the private practice, the author has provided physical therapy services to the Ann Storck Center Preschool (ASCP) for the past 4½ years and to the Broward Association for Retarded Citizens Parent Training/Early Intervention Program (PT/EIP) for the past 1½ years. Both contracts provide for direct evaluation and treatment and indirect consulting services for the staff and families of the children. Significant indirect service time involves teaching parents and staff techniques of physical management and exercise of the children during the daily

activities. The Florida Department of Health and Rehabilitative Services/Developmental Services Program Office is the referral source for both agencies.

The ASCP serves 24 students, who attend one of two classes. Each class has one teacher and two to three aides and daily volunteers and student teacher interns. One additional special educator administrates and supervises the programs. The preschool is one unit of the Ann Storck Center, Inc., a multiunit facility providing both day and residential programs for developmentally delayed children and adults. Nursing, social, and psychological services as well as physical, occupational, and speech therapies are provided to all clients. All teachers and other professionals have at least a college degree or comparable work and continuing education experience with preschool exceptional children.

The PT/EIP is one component of the Broward Association of Retarded Citizens, Inc. (BARC), which also includes residential, preschool and workshop facilities. The PT/EIP supports, assists, and trains parents of handicapped children. Intervention, according to the BARC brochure (1984), includes "an in-depth evaluation of the child, a comprehensive training program for the parent, regularly scheduled home visits to teach stimulation techniques, referral services and supportive counseling for parents and siblings."

The parent training utilizes behavior modification techniques and the Portage Model curriculum for development, as described by Cartwright (1981). Between 80 and 90 families are serviced by two behavior specialists, three parent trainers, one social worker, and one physical therapist. All service providers are required to have at least a bachelor's degree.

The author currently provides physical therapy gross motor programming for 20 children at the ASCP and direct regular therapy treatments to 20 children at the PT/EIP.

CHAPTER II

STUDY OF THE PROBLEM

Description of the Problem Situation

With increasing evidence that very young infants are relatively competent organisms capable of participating actively in interactions with their world, focus has become more and more on enriching the child's environment to maximize his interactions and facilitate his normal development. This environmental intervention has taken the form of early educational programs for infants as well as parent educational and/or emotional support groups. Gallagher (1975), Meisels (1985), Filler (1983), and Casto and Mastropieri (1986), among others, report overwhelmingly positive effects of early education programs. Likewise, Heisler (1972), Wagner (1978), and Turnbull and Turnbull (1978) have attested to the positive benefits of parent support groups. This trend toward early intervention has been especially beneficial for young children at risk for developmental delays and their parents. Meisels (1985), Noone (1980), Cartwright (1981), and Garwood and Fewell (1983) are among the many authors who have presented positive results of

early intervention for these children. A recent meta-analysis by Casto and Mastropieri (1986) concluded that early intervention programs resulted in moderately large immediate benefits for handicapped populations as measured by such outcome variables as IQ, motor, language and academic achievement.

As a physical therapist who has been involved with early intervention programs since the 1960s, the author has witnessed major changes in the therapy delivery systems based on the most recent effectiveness information. From the early model of one half-hour treatment twice a week for the young preschooler without his parent's presence, delivery has evolved to the currently advocated model of frequent treatment-instruction sessions for parents, child, siblings, and relevant others to teach them appropriate techniques of physical management and normal movement stimulation. In this way the developmentally delayed child receives therapeutic sensorimotor treatment 24 hours a day from all his caregivers. Finnie (1975), Harris and Tada (1983), Campbell (1984), and Redditi (1983) documented the effectiveness of this approach, which the author implements at both the ASCP and the PT/EIP. With the infants at the PT/EIP, who come weekly for direct physical therapy treatments, the caregiver(s) who brings the child participates in the session and is given verbal, written, and demonstration-with-

modeling practice in home carryout of the treatment session. The instructed caregiver is almost always the mother, occasionally a grandmother, sibling or baby-sitter, and rarely the father.

At the ASCP, which the therapist services weekly, the teachers and aides (all female) are instructed in appropriate gross motor programming for each child. All children attend school five weekdays from 9:00 a.m. to 3:00 p.m. Parent-therapist interactions occur at the annual individual educational plan meetings, at a minimum of one therapy session per school year, at the parent group meeting when the therapist is the speaker (one to two meetings per year), and more frequently as needed. This therapist tries to maintain close, ongoing, informal contact with the family via progress notes, telephone reports, and information via the teacher. Unfortunately again, with few exceptions, contact has always been with the mother or a close female relative, despite the increasing body of knowledge of the importance of father's influence on his child's development.

Lamb (1981), Cath, Gurwitt and Ross (1982), Parke (1981), Phillips and Anzalone (1978), and Pederson (1980) all verify the important role of the father in infant development. Brazelton (1985) discussed this issue recently in a popular magazine. The motoric-delayed child, that is to say, the one receiving physical therapy, particularly needs

his father's type of interactions, which are characterized by more physical contact, greater movement, and sensorimotor games. Mother-child interactions on the other hand are usually more visual, verbal, and caretaking-related ones. However, with an infant who may have some physical problems, fathers are reluctant to play physically with the child, and typically feel inadequate to assist in the caregiving tasks, which may require special management techniques. Therefore, they frequently withdraw from all direct contact with the child and serve only in an indirect father role and as a support for the mother. The mother then must assume the total direct parenting role, which, for an exceptional child, involves greater physical, mental and economic stress, as well as a greater time commitment than for a child without problems. Schell (1981) and Gabel, McDowell and Cerrato (1983) have documented these many stresses. Consequently, the mother becomes overstressed physically and emotionally, often resulting in alienation between parents, father and child, and frequently mother and other siblings. The exceptional child attains submaximal achievement often because of deprivation of paternal input, a disruptive home environment, and total maternal dependence.

If the situation were rectified, parents would share the caregiving tasks and home intervention developmental

task training for their exceptional child. For this to happen, fathers must gain confidence and competence in physically handling and developmentally stimulating their exceptional young children. They must also learn to interpret their children's often deficient cues and respond with appropriate responsive play. This ability and security for each father can be gained easily by his participation in the early intervention treatment sessions and/or home instruction sessions, where he can learn how to interact with his child. Unfortunately fathers almost never come to the physical therapy treatment sessions. On the rare occasions when a father does attend, usually the initial evaluation, it is typically in the role of chauffeur, emotional support for mother, or baby-sitter for siblings. Only rarely is he involved directly with his child. Therefore, the problem addressed by this practicum was the lack of father-exceptional child sensorimotor interaction.

Documentation of the Problem

The evidence that this problem existed at both the ASCP and the PT/EIP was documented in several ways. A written poll of the three PT/EIP home visitors' client rosters (see Appendix A) revealed that of 61 current active families, 22 are single-parent households (21 mothers and 1 father). Of the 40 remaining two-parent households, only 11 have

demonstrated father's interest in the early intervention program by his presence for at least one visit by the early intervention professional. At least five other fathers had expressed interest in participating but were unable to do so because of work hour conflicts, since the home visits occurred weekdays between the hours of 8:00 and 5:00. Of the 61 clients, 20 infants (0 to 18 months) were receiving direct, physical therapy treatments weekly with a daily home exercise program instructed to the parent. Of 15 two-parent households, only five fathers had been able to attend one or more sessions and only two regularly interacted with their child in the physical exercise games at home. At least ten had expressed interest in attending the sessions either to their wives or to the therapist but an inflexible work schedule had prevented it.

Twenty-four children were enrolled at the ASCP, of whom 20 were on therapeutic gross motor programs because of physical disabilities. Of the 12 two-parent households, four fathers had demonstrated interest in their child's therapy program by attending group parent meetings with the therapist or participating in an individual therapist-parent home instruction session.

At least five fathers had verbally expressed to the therapist their fear and feelings of incompetence in handling their physically involved children. One especially

supportive father, who is very involved indirectly with his child, offered to baby-sit his boy one Saturday but expressed his sense of failure when he realized that he didn't know how to feed his son or even remove his child's pajamas! This same father communicated his frustration because of the lack of feedback he received from his son during interactive play.

All of the program administrators or social workers of Broward County early intervention programs, when polled individually, expressed a need to involve more fathers but reportedly had not been able to do so. They expressed concern for the higher than average divorce rate among their client families, and viewed positively any efforts to encourage more active involvement of fathers.

There is ample literature evidence of the lack of father involvement in early intervention programs serving families with developmentally disabled individuals. As reported by Noone (1980), of 92 such model programs funded federally, the vast majority focused on mother as the major figure to attend the training sessions and to provide the home intervention. In a few programs fathers did attend the training meetings, but only one program was reported by Noone which specifically trained fathers to provide some home intervention tasks. Keenan and Suelzle (1982) report

that, of 329 parent questionnaires regarding the disabled child, "almost all were completed by the mother."

Analysis of the Causes

The lack of father involvement in early intervention programs has several probable causes. Lack of father attachment because of bonding deficiency must certainly be considered. Any type of atypical birth places the normal bonding mechanisms at risk as documented by Jeffcoate, Humphrey and Lloyd (1979), Fewell (1981), Gath (1985), Sameroff (1980), Cleland and Swartz (1982), and Bolton (1983). However, efforts to deliberately facilitate bonding have uniformly been directed to the mother as evidenced by Bolton (1983), Bromwich (1981), and Gomes-Pedro, de Almeida, da Costa and Barbosa (1984). This was verified by personal reports from both parents of many of this author's physical therapy clients. Mother then learns to resolve her conflicting feelings about her child as reported by Mackeith (1973). Fathers too frequently do not resolve their mixed feelings about an atypical neonate or build an attachment to the child, because they usually do not have to deal directly with the child in caregiving tasks. It is the author's observation that mothers all too often harbor this delayed adjustment of the father to his atypical infant. For example, in a recent conversation, a mother of a 10-month-old

boy with Down syndrome stated that they had not attended a Parents of Downs picnic because, "I don't think Jim is ready for that yet." Mothers do not usually have this buffer system and must provide immediate direct care for the child. Hence the attachment develops and grows.

Because of mother's greater direct contact with any newborn child she usually becomes more knowledgeable about and competent in caregiving tasks than father, as depicted in Greene's journal (1984). Even a local community college advertises parenting classes as mother-child participation classes, and schedules them for weekday mornings. Efforts are underway to change this bias against fathers of normal babies as evidenced by Brazelton (1985) and Logan (1985). However, with an exceptional child, the problems and distancing between father and child are even greater. Fathers are even more reluctant to interact with a child who requires greater skill and time for caregiving, may be medically unstable, and is less responsive to his caregiver. Gabel, McDowell and Cerrato (1983), Jeffcoate, Humphrey and Lloyd (1979), Bavin (1975), and Finnie (1975) have all documented father's reluctance to interact with an exceptional child. The mother-child dyad then becomes unusually strong and the father-child dyad even weaker. This tendency increases with time, resulting in greater alienation of father and child. With mother's increasing knowledge of

the child's exceptionality and methods of managing it, father's feelings of inadequacy grow. Mothers often foster father's incompetence in this area by not including him or teaching him the appropriate handling techniques. Many seem to enjoy their superior expertise and father's inadequacy. This of course further alienates the father, who then withdraws further from interactions with the child and frequently from the wife as well. Swick (1983) discussed the problems of an unusually close family dyad, which not only excludes others but also results in the lack of family triad interactions. Often major family problems result. There have been documented higher divorce rates among parents of developmentally disabled infants (von Wendt et al., 1984), higher abuse rates for exceptional children (Sameroff, 1980), and increased incidence of psychological problems with both parents and developmentally delayed children (Gliedman and Roth, 1980). One cannot help but speculate that the increased physical burden on the mother, absence of the father from caregiving tasks, and increasing alienation of the father from his child and wife contribute to these statistics.

One final cause must be addressed: that of the total neglect of father-infant considerations by medical and therapeutic service providers. Ferholt and Gurwitt (1982) revealed the alarming statistic that fathers are absent in

97 percent of pediatric office visits. Sheftel and Sheftel (1984) and Cone, Delawyer and Wolfe (1985) support these figures by providing additional evidence that fathers are typically excluded from their child's care by professionals. Unfortunately, medical offices, therapy centers, early intervention programs and preschools all are open during the typical daylight working hours of a 5-day week. This usually conflicts with father's work schedule which is often inflexible. Markowitz (1984), Keenan and Suelzle (1982), and Winton and Turnbull (1981) attest to logistic problems as being a major factor in the lack of father involvement. As reported by Ferholt and Gurwitt (1982) and verified by Greene (1984), even when fathers do attend intervention or evaluation sessions, they are excluded by the professionals and intimidated by the service atmosphere. It has been amply demonstrated that father is at least equally competent as a caregiver and playmate for his infant as mother, and should be encouraged to interact with his developmentally disabled infant. Infant, father and mother would benefit from the involvement. Unfortunately, the author has not observed use or even acknowledgment of the important father-infant relationship in any early education or therapeutic intervention for developmentally delayed infants in her many years of experience.

Relationship of the Problem to the Literature

Indirect Role of the Father

As Demos (1982) so aptly stated, "Fatherhood has a very long history, but virtually no historians. Its only invariant aspect is the biological one; all else is fluid and changing." The father role fluidity is tied to the changing family role within a society. However, we can observe in historical perspective that in the development of the modern world direct paternal involvement in child rearing - particularly in the care of infants - was nonexistent. A noted female anthropologist has referred to the father as a "biological necessity but a social accident." In fact, though, the father has had an indirect role of economic support for the family and emotional support for the mother. According to Segal and Yahraes (1979), John Bowlby reported to the World Health Organization in 1951 that "The father is of no direct importance to the young child, but is only of indirect value as economic support and in his emotional support of the mother." This historic, indirect role should not be underrated because it continues to contribute greatly to the emotional climate for the infant in the family. Parke (1981) found that emotionally supportive husbands facilitated their wives' adjustment during pregnancy, as

well as their enjoyment of the state. Other investigators, such as Phillips and Anzalone (1978), confirm that father's presence is significant in the birth process. For example, women whose husbands participated in both labor and delivery reported less pain, received less medication, and felt more positive about the experience than women whose husbands did not participate. Bloom-Feshbach (1981) reports that mothers are more interested in nursing and the care of their newborn when fathers are emotionally supportive. This indirect influence of the father on his child continues through the child's development. Keniston (1977) reports that the most effective way to help our American children is to provide sufficient income for the family. This is again acknowledging the indirect effect of the father's traditional role on his child's development.

Direct Role of the Father

The father's direct role in infant child rearing historically was either nonexistent or not acknowledged in the literature. As Demos (1982) explains, the father's role with older children was direct but was a distant one of serving as a model for identification for sons, of providing authority, and of nurturing a healthy moral sense. The central theme of studying paternal influence was on the child's sexual role development and gender identification, according

to Biller (1981). Lamb (1981) points out that inferences about paternal influences on older children were largely dependent on studies of father absence and were confounded by many variables. Therefore, direct versus indirect influences could not be separated. Bloom-Feshbach (1981) reports that in 1977 a national survey indicated that mothers assumed direct responsibility for household and child rearing tasks, while fathers assumed direct responsibility for deciding on children's allowance as well as teaching them sports and bicycle riding, and shared equally with mothers in disciplining measures. According to Lamb (1981), this role division was a direct outgrowth of the industrialization of western societies and the scientific investigations of the day focused "naturally" on this traditional nuclear family pattern. Therefore, socialization theories were elaborated on mother-child relationships, and the direct influences of the father were devalued.

By the late 1960s scientific as well as societal attitudes began to change. Lamb (1981) cited the breakdown of traditional family structuring, as well as recent research evidence on characteristics of infants and their interactions, as being responsible for an interest in the role of the father in early child development. Parke (1981), Lamb (1981), and Greenberg and Morris (1982) reported that

fathers themselves were beginning to seek active involvement in direct relationships with their infants as part of their redefinition of what it means to be a father. Finally technological, economic and ideological changes in our society are forcing fathers to assume more of the early infant and child care responsibilities as noted by Lamb (1981), Parke (1981), Cath, Gurwitt and Ross (1982), and Eiduson (1980).

Hersh and Levin (1980) found that early exposure to the new infant has an effect on the father as well as the mother, and promotes closer bonding and improved health of the infant. Parke's findings (1981) verified those of Hersh and Levin (1980), and he further found that fathers who had physically handled their neonates were spending an hour more daily with their 3-month-old infants than fathers who had not had the early exposure. Likewise, Parke (1981) reported that fathers who cared for the newborn because of the mother's prolonged recovery from Caesarian delivery were found to be significantly more involved with caregiving activities of their 3-month-old infants than other fathers. Both Parke (1981) and Pedersen (1980) found that fathers and mothers are equally sensitive and active to newborn cues and are equally competent as caregivers when either assumes this role. Lamb (1981) noted that infants protest separation from either parent by at least 18 months of age and show

attachment to both parents by approximately the same time - usually 8 months of age as reported by both Lamb (1981) and Pedersen (1980). In addition, they both found the infant selected the most appropriate caregiver: mother for distress situations, father for affiliative behaviors.

Both Lamb (1981) and Parke (1981) observed that mothers and fathers have different styles of play behaviors with their infants. Fathers engage in more physical games such as bouncing and lifting, whereas mothers engage in more distal watching games. Fathers engage their infants in more novel or idiosyncratic games than mothers, who prefer the more conventional activities, such as peek-a-boo and pat-a-cake games and stimulus-toy play. Yogman (1982) investigated the social interactions of newborns from 2 weeks to 6 months of age by videotaping them in unstructured interactions with either mother or father. He found that the interactions of the father were more heightened and playful than those of the mother. Mothers' reactions were reported as being more smoothly modulated and contained. Fathers engaged in more game playing with the infant, with tactile and movement games used more frequently than visual attending games.

In other than play situations - for example, caregiving tasks - the contrast between mother and father in type of preferred interaction with the infant has been substantiated

by Parke (1981), Lamb (1981), Yogman (1982), and Hersh and Levin (1980). These same researchers attribute the differences primarily to the continuance of mother's role as primary caregiver with father serving in a more secondary, less frequent role as caregiver. Eiduson (1980) reported that mother's role as primary caregiver and father's role as a more social playmate for the infant is found in nontraditional as well as traditional home environments. However Pedersen (1980), in observational studies of 5-month-old infants at home with either one or both parents, reported very different results. In a dyad interaction situation fathers and mothers showed very little difference in type or frequency of interactions, but the infant-focused behaviors of both parents decreased significantly in a triad interaction. Behaviors which required less focused infant attention, such as bouncing, rocking and physical play, thus increased. Pedersen speculates that since father-infant interactions are most frequently in a triad, these particular physical behaviors evolve. Parke (1981) also found different styles of play of both mothers and fathers dependent on sex of the child as well as birth order. Generally fathers played longer, more frequently, and more vigorously and verbally with first-born sons. These studies have verified the important direct as well as indirect role of the father in the development of the infant. All the reported

studies, however, were done on healthy, developmentally able children. Very little attention has been focused on the father's direct interactions with the developmentally disabled infant. Parke (1981) asserted that fathers do not show the typical physical style of play with all types of infants. In a study of father-premature infant interactions in the hospital and soon after the infants were brought home, it was observed that fathers did not exhibit their characteristic higher rate of physical play. Parke did not observe the relationship later to see if the style of play continued to differ as the child matured.

This Parke (1981) reference was the only one found during this literature review which systematically examined father's altered interactive behaviors based on his infant's physical state. Unfortunately, decreased father-type physical play is probably more the rule than the exception with developmentally delayed infants. It has been well documented by investigators such as Sameroff (1980), Schell (1982), Cleland and Swartz (1982), and Bolton (1983) that an atypical infant significantly alters the parent-infant interaction. This occurs because of medical management or mismanagement, decreased infant interactive ability, and fear or feelings of inadequacy on the part of the parent. Although, recently, efforts have been made to include mothers in caretaking and programming for the

developmentally delayed infant to facilitate bonding (as documented by Gomes-Pedro, 1984, and others) much less attention has been given to providing for father's need for bonding assistance. Research and intervention attention has been heavily weighted toward focusing on the necessity for mother-infant bonding. However, Parke (1981), Lamb (1981), Hersh and Levin (1980), Yogman (1982), and Greenberg and Morris (1982) have made us keenly aware of the importance of father-infant bonding in maximizing the infant's developmental potential. The father's unique interactive early sensorimotor stimulation may be precisely what his developmentally delayed infant needs, according to the research reviewed by Girolami (1983) and Brazelton (1985).

Fathers' Involvement in Early Intervention Programs For Developmentally Delayed Infants

Schell (1982), Sameroff (1980), Bolton (1983), Stengel (1981), and Cleland and Swartz (1982) have all documented the trials and tribulations experienced by families of developmentally disabled infants. The actual physical and financial drains have been poignantly described by Lucca and Settles (1981) and Gliedman and Roth (1980) and by many parents themselves, as documented by Turnbull and Turnbull (1978), Winton and Turnbull (1981), Redman-Bentley (1982),

and Keenan and Suelzle (1982). Society has answered this need by developing early intervention programs to assist the families and/or facilitate the child's development to his maximum potential. Karnes and Teska (1975), Cartwright (1981), and more recently Garwood and Fewell (1983) and Sasserath (1983) have documented different types of early intervention programs. Meisels (1985), Pines (1982), Connor et al. (1978), and Casto and Mastropieri (1986) have contributed evidence of the overwhelming success of early intervention programs, whether home or center based, for developmentally disabled infants and their parents. Bromwich (1981) developed a parent-infant training model in which she outlined specific intervention strategies. These early intervention programs uniformly use either a parent-professional partnership for intervention with the child or provide professional assistance to the parent, who then assumes the role of teacher or primary interventionist with the child.

However, when we examine closely who precisely is meant by "parent," it becomes dramatically clear that it refers to mother only. Brown (1981) referred consistently to "the parent," but every illustration in the book was of a woman and a child. Bromwich (1981) titled her publication Working with Parents and Infants, but most of the sentences read similarly to the following: "The infant attends to his

parent's face when she talks to him"; "If the parent perceives the staff as 'infallible,' she may feel inhibited and unable to express her insecurities about her mothering or her ambivalent feelings toward her infant"; or "The parent needs to gain confidence in her own decision-making power." Not one sentence of the book was addressed to the father or his role. In almost all the literature reviewed on early intervention programs, including the studies on strategies, effectiveness, applications, and parent response, "parent" was used as a euphemism for mother. The literature referring to family involvement was equally evasive as to a definition of family. For example, Bricker and Casuso (1979) used family and parents interchangeably, but did not say that families and parents are individual people who each interact in very different ways with the infant, each other, and other family members.

Several early intervention programs fortunately found a role for father. Brown (1981), in describing the curriculum of the Meeting Street School, listed activities specifically to encourage father-infant play. Von Wendt et al. (1984) designed a physical therapy parent-centered program for cerebral palsied infants with special emphasis on father's inclusion. Parent responses indicated satisfaction with the program, and statistics indicated a lower than expected number of divorces of the parents had occurred. Bavin (1975)

discussed the importance of the father playing with the cerebral palsied infant and specifically addressed the infant's need for his different style of play behaviors. Markowitz (1984) reported that, in telephone interviews of 15 early childhood education programs, although efforts were underway to involve fathers in educational and support activities, many fathers' work schedules prevented their doing so. Noone (1980) reported on two programs directed solely to fathers of young children with developmental disabilities. One involved weekly evening counseling sessions and another involved a Saturday morning father-child play participation group. The second approach was reportedly so successful that a second group, at a different location, was added and a waiting list for both programs is now a reality. This evidence substantiates the literature that fathers want to be involved in the care and activities of their young children, even though the children may have developmental delays. It is our mandate, as concerned professionals, to make an effort to include these fathers in our programs.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

With increased evidence of father's competence as caregiver and his unique contributions to infant interactions and development, it was planned to involve more fathers with their exceptional children. The first goal was that a greater number of fathers would demonstrate increased knowledge and awareness regarding physical development, and both the importance of and opportunities for father-child interactions. Secondly, a greater number of fathers would participate in caregiving and play activities with their exceptional children. In addition, a greater number of fathers would demonstrate some responsibility in their exceptional children's therapeutic program carryout at home. Father, or another household member, would then communicate the value and positive effects of the increased father-child interactions.

Behavior Expected

It was anticipated that:

1. A greater number of fathers would attend physical therapy sessions and/or read developmental information.

2. A greater number of fathers would demonstrate knowledge of the importance of father-child interaction by spending at least a half-hour per day with their children.

3. A greater number of father would participate in home exercise activities by completing at least one assigned activity per day, three days per week with their children.

4. At least 50 percent of participants would demonstrate positive benefit from the program by requesting continuation of the father intervention sessions.

5. Of participant fathers, at least 50 percent would show increased development and physical handling knowledge.

Mechanism for Recording Unexpected Events

Documentation of each physical therapy intervention session is the rule and practice of the profession. It continued throughout this 3-month practicum period and served as the mechanism for recording unexpected events in the direct intervention, for example, a language barrier with one father. A log was also maintained from May 1, 1985 through February 28, 1986, at which time the implementation was completed. The logbook served as the mechanism for

recording unexpected events in the process of implementation, such as dissatisfaction with the evaluation forms. The necessary revision of the interview forms (to be partially oral and more specific) and the pre-post test (to be more pictorial) evolved by telephone consultation with the practicum advisor and was recorded in the log.

Measurement of Objectives

The specified terminal behaviors were measured by:

1. Attendance records at scheduled sessions, which were documented in the physical therapy medical file as well as on a separate schedule of implementation. This measure was chosen because of its simplicity and its usefulness as an index of father's interest in his child's program and his willingness to learn to better interact with his child.

2. Comparison of pretest-posttest scores. A 10-item evaluation instrument was developed by the author to assess the father's knowledge of his child's developmental and physical management needs. A primarily pictorial multiple choice test, in which father had to circle the correct picture, was developed to circumvent language problems. A copy of the test is included in Appendix B to this report.

3. Number and frequency of entries on father's "Daily Data Sheet." On the first home visit all fathers were given written and pictorial exercise sheets as well as a "Daily Data Sheet" for recording carryout documentation of the daily exercises (see Appendix C). The use of the sheet was explained verbally and demonstrated by the therapist. It was desired that the daily recording would serve as both motivation for and feedback of the daily structured home exercise program.

4. Oral and/or written interview information sheet completed by the father and/or therapist. Initially this was an oral questionnaire completed by the physical therapist at the time of the first session. However, as fathers tended to be non-specific in their oral responses and appeared somewhat threatened or defensive due to the nature of the questions, it was decided to revise the questionnaire and carry out the procedure before the second sessions. Both questionnaires are included in Appendix D.

5. Tally of parent requests for continuation of the program. This information was included on the second questionnaire.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

In seeking possible solutions, one must examine not only the causes of the problem but also the efficacy and feasibility of each solution for that particular person in the given situation. Employment in an educational rather than a medical facility eliminated facilitation of neonate father bonding as a possible solution. Likewise, a physical therapy, early education specialist is not professionally qualified to implement father counseling groups. Therefore, the solution strategies considered all revolved around ways to increase each father's current, direct interactions with his own handicapped child.

Moxley-Haegert and Serbin (1983) found that parents who received general developmental education material, in addition to an early intervention home program for their child, were more motivated and demonstrated increased compliance with the home program. Their children gained more skills and continued to do better, even one year after the intervention, than those of the control group, who had received

a home program without the educational component. Sasserath (1983) and Cone, Delawyer and Wolfe (1985) found also that the higher the parent education level the greater the parent participation for both fathers and mothers. Therefore, the first solution considered was that of sending educational materials home for fathers to read. Although this strategy would circumvent the conflicting work schedule problem, it was rejected for two reasons. There was a high probability fathers would not read the materials, and also this strategy would not facilitate direct father-infant interactions.

A second solution considered was that of sending home both child development information and a specific written task for father's implementation with his child. Although this solution would facilitate direct interactions, it was rejected also. Mayo (1981), Sheftel and Sheftel (1984), and von Wendt et al. (1984) reported positive effects of direct parent-professional contact. Hendrickson and Hester (1977) found that direct modeling was a very effective training method for parents of handicapped children. Sheftel and Sheftel (1984) reported also that direct instruction to the caregiver by the professional in the techniques of play responsiveness to child-led interactions not only produced positive behavior changes, but also increased confidence in the caregiver. In addition, it was felt that if the

information were sent home via mother, her childcare burden would be increased even more and her role as the child expert in the family would be enhanced to further undermine father's confidence.

Cartwright (1981), Cone, Delawyer and Wolfe (1985), and Swick (1983), in discussing the many parental roles, agreed that father typically serves the indirect, supportive role for his child. Winton and Turnbull (1981) clarified the distinction between direct involvement with the program and parental direct involvement with the child in the program and suggested that many fathers prefer the former and should not be forced into the latter role. However, Tarran (1981), Redman-Bentley (1982), and von Wendt et al. (1984) found that many fathers, as well as mothers, desired an increase in their direct involvement with the child in his program. Many of the fathers of the children currently followed by this therapist were already directly involved with the program and were serving in the indirect supporting role for their child. Several of the fathers had expressed a desire to increase their direct therapeutic involvement either at home or at the treatment sessions. Therefore, it was decided to schedule several father-child therapeutic sessions individually or in small groups at a time and place convenient for the father.

Description and Justification for Solution Selected

At least one individual physical therapy session was scheduled when and where an interested father could attend to review the home program and physical management techniques for his child. Each father received written instructions and handling practice, as well as three handouts on child development and, depending on the age of his child, one to three handouts on fathering (see Appendix E). Each father was also requested to do at least one father-child home intervention task daily and report back to the therapist on its implementation. During each session, seven of the ten participant fathers took the short test of knowledge about appropriate handling for their child.

Although it was proposed to test fathers at the beginning and at the end of each session, the session length negated this aspect. Since all fathers were scheduled for two sessions, the test was administered at each session for a pretest and posttest comparison. For two fathers whose children were older and ambulatory, the test was inappropriate. One other father was excluded from the test because of the family's newness to the program, the lateness of the hour, the fussiness of the child, and other relevant factors. It was judged that to add a "test," which might produce even greater anxiety, at that point in time was

inappropriate. All fathers were interviewed at each session as to their time and activity commitments to their children. The recording form for this component evolved, as explained in Chapter III, from a means of recording an oral interview to a written questionnaire which the father completed at the end of his second session together with the posttest.

Each father training session was one to one and one-half hours in length. At the first session, following introductions and an explanation of the practicum process and goals, the father took the pretest. The oral interview was then conducted and the relevant handouts issued and explained. Direct intervention with the child followed, with the therapist demonstrating the physical handling techniques and/or exercise games. The father then practiced the techniques of handling with his child. Upon completion of each exercise game, the picture and written exercise instructions were reviewed and clarified as necessary. Upon completion of the entire exercise series, the daily data sheet was explained to the father and the session ended.

The second session, scheduled between two and three months following the first one, began with the father and child demonstrating the physical handling and assigned games. The therapist then corrected and/or revised the program as necessary and urged continuation of the father-child interactions, even though that session completed the

practicum project. An information discussion followed, including physical development in general and as relevant to that particular child, the importance of father-child interactions, and the handout information. An effort was made by the therapist to individualize the situation by assisting the father in establishing a definite, workable time of day in which he could interact with his child in a dyad relationship. The father then completed the posttest and the final written interview. Sample forms, in the appropriate order of administration, are included in Appendix F.

This solution strategy was selected for a number of reasons. Most importantly, several fathers had expressed interest in more direct involvement and had responded affirmatively when approached with this possible solution. Secondly, despite overwhelming evidence that increased parental education and participation results in greater developmental gains for children as reported by Campbell and Wilson (1976), Lewis (1984), Harris and Tada (1983), Stile, Cole and Garner (1979), and Campbell (1984), physical therapy infant stimulation programs have continued to focus on traditional models of service delivery. Redditi (1983) reports that many physical therapists not only continue to provide traditional service delivery of two to three half-hour treatments weekly but also are unaware of the

literature regarding more effective methods of intervention. Therefore, it was hoped that this program when implemented and publicized could serve as a demonstration model for other pediatric physical therapists. Parents uniformly report that scheduling conflicts, transportation, and other logistic problems are the biggest factors in lack of participation, according to Redman-Bentley (1982), Tarran (1981), Winton and Turnbull (1981), and von Wendt et al. (1984). Therefore, this implementation utilized a flexible time and place format to facilitate maximum father participation.

Stile, Cole and Garner (1979), Swick (1983), Campbell and Wilson (1976), Sheftel and Sheftel (1984), and Lewis (1984) offered specific implementation strategies for effective parent-infant programs. Such suggestions as child initiated play training, printed handouts with illustrations, individual sessions, provision of contact for feedback, and use of modeling as a teaching tool were incorporated into the design. The Meeting Street School Parent Program (Brown, 1981) and the University of Washington Fathers and Infants Program (Noone, 1980) were the only two comparable programs, which specifically trained fathers in direct physical interaction skills. They both have demonstrated their effectiveness and popularity over several years.

CHAPTER V

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Results

The results of the practicum were generally positive, with a greater number of fathers attending physical therapy sessions, participating in appropriate home exercise play activities, and demonstrating increased relevant knowledge about their child's physical development and disability than prior to the intervention. Fourteen potential participants, seven at the PT/EIP and seven at the ASCP, were contacted by the physical therapist regarding increasing their participation in their child's physical therapy program. They were given several possible dates and times for scheduling the first therapy session. Two fathers did not respond and were unable to be reached by telephone. Two other fathers scheduled appointments but did not keep them (one cancelled). Ten fathers (71 percent of those contacted) attended the first therapy session and followed through at least partially with the exercise program. Nine fathers (64 percent) attended both sessions. Since the fathers (two) who regularly attended the therapy sessions already were excluded

from the practicum project, this represents a strong increase in number of fathers involved with their exceptional children's programs. Only two participants had previously attended a therapy appointment at all.

It is interesting to contrast the two groups of fathers: ASCP and PT/EIP. Seven fathers were contacted at each facility. All seven contacted at the PT/EIP scheduled appointments and only one cancelled because of his late working hours. The remaining six fathers participated in both sessions (86 percent). The mean age of their children was 9.17 months. Of the seven fathers contacted at the ASCP, two did not respond and one scheduled the first session but did not show up or respond to rescheduling attempts. A fourth father attended the first session, did not show up for the second scheduled session, and refused rescheduling attempts. Therefore, three fathers participated in both sessions (43 percent). The mean age of their children was 38.67 months. The contrast between the participation of fathers of the older children who attend a special daily preschool and the fathers of the younger children, who do not attend an educational program, could be attributed to several factors. Parental burnout as elaborated by Schell (1981) and alluded to by Stile, Cole and Garner (1979) could certainly be a factor for these older,

more severely handicapped children. Another possible factor could be a feeling that therapy should be done by the school as expressed by a parent saying, "I can now turn her over to someone else ... I never have to think about it," in the article by Winton and Turnbull (1981). Although Cone, Delawyer and Wolfe (1985) had found family income and educational levels positively correlated with parent participation, this was not a factor in this practicum as the two groups of fathers were similar in these respects.

The pretest-posttest score differences also met the stated objective of the practicum. All fathers scored higher on the posttest than on the pretest, with a mean gain of 2 points. That is to say, out of 10 questions, they got 2 more questions correct on the posttest, on the average. Therefore, they demonstrated increased knowledge of their children's development and physical handling needs.

The "Daily Data Sheet" compilation of exercise completion by the fathers yielded positive evidence that a greater number of fathers were participating in the home exercise activities than previously. Two had completed daily carry-out of all given exercises for the entire 2-month period. Interestingly, one of these children was the oldest in the ASCP and one was the youngest in the PT/EIP. Four other data sheets were partially completed, with three logged daily for 2 to 4 weeks, followed by scattered entries, and

one logged once a week over the 2 months between the sessions. Three were returned blank and one never returned. The results meet the stated objective, of greater regular father participation in the home exercise program, with six of ten fathers (60 percent) complying with the recording task. However, it was apparent, from verbal feedback from fathers and other household members and from observation of father-child interaction by the therapist, that the recorded data did not reflect the whole picture. Several fathers were doing the tasks but not taking time to record them, and one father had lost his record form. This compliance with a home exercise program verifies the findings of Cone, Delawyer and Wolfe (1985) that fathers preferred involvement in educational activities at home.

The oral interview of the first session and the written interview of the second session were expected to show an increase in commitment time of father to his child to at least 30 minutes per day. Of the ten fathers orally interviewed, seven indicated that their wives did "almost all" the caretaking tasks for the child. All of these fathers worked full time and had wives who were not employed outside the home. Two fathers indicated they assisted in caregiving tasks, especially bathing and dressing activities. Both of their wives worked full time outside the home. One father, who was unemployed, said that he did "most" of his child's

care; however, in telephone contact two months later, he indicated that he did very little of her care, since he was now working and taking classes. All fathers indicated they "played with" their child for from ½ hour to 3 hours per day, usually in the evening. The traditional division of father role activities and mother role activities found with these parents was stated previously by Lamb (1981), among others. It was clear that seven of the ten were referring to triad, indirect time when they held the child while mother fixed dinner, while watching television after dinner, and other similar times. Only two fathers specified dyad time when they directly interacted with their child at a specific time each day. These were the same two fathers of the oldest and youngest children who completed and recorded all assigned therapy tasks. All fathers reported an increase in child-father interaction time on weekends. One father reported spending considerably more interaction time with his exceptional child than with her twin sister because "she needs me more." Pedersen's observations (1980) addressed the differences of activities in dyad and triad interactions. He also observed that triad interactions are far more frequent between child and father than dyad ones.

The written interview questions of the second session were completed by all nine participants. The compilation

results are presented in Appendix G. All participants expressed positive benefits from the program and requested continuation of father inclusion in the physical therapy programming. Nine fathers (100 percent) indicated that the direct contact with the therapist was the most beneficial component, with two indicating that the developmental information was also helpful. This finding verifies the importance of direct professional-parent contact for successful parent participation as previously reported by Mayo (1981), von Wendt et al. (1976), and Sheftel and Sheftel (1984). Eight fathers (89 percent) felt that the sessions had changed them and/or their children for the better by changing the manner and/or the amount of direct father-child interaction time. Assessment of amount of father-child time increase following the practicum sessions was difficult because most fathers were already "playing with" their child one half-hour or more per day as reported at the first session. Although the written interview of the second session indicated an increase of one to three hours on weekdays, it is not possible to determine if this is direct contact and/or dyad time. It was difficult to get specific answers to the questions as they were presented. There was no increase in caregiving time by the fathers, as the reports were still "rarely," "zero to once per week" (for diaper-

ing), "wife does these things," etc. This may be a function of the employment status of the households rather than a function of father's uneasiness or feelings of incompetence with an exceptional child. Both two-working-parent households shared caregiving tasks. Thus, the objective of "increasing father's participation in caregiving and in play activities" was met only partially. Both the quantity and quality of the play time was increased. The physical handling of the caregiving tasks by the two fathers who assisted at home improved in therapeutic quality, according to the participants and their wives. However, the remaining seven fathers did not show an increase in caregiving time with their exceptional children. In the light of Lamb's (1981) and Cone, Delawyer and Wolfe's (1985) findings, this practicum goal objective was probably not a realistic one. All other goals as outlined in Chapter III were fulfilled.

The handout information was supplemental to enhance the home program carryout, as specified by Moxley-Haegert and Serbin (1983), and therefore knowledge gains from the information were not measured. However, at least 50 percent of fathers commented on aspects of a handout, asked questions of clarification, or in some way indicated that they had at least perused the handouts.

Conclusions

The positive outcome of this practicum verifies the results of Lamb (1981), von Wendt et al. (1984), Tarran (1981), and Redman-Bentley (1982) that fathers do want to become involved with their exceptional child's therapeutic program. By carefully addressing factors which maximize opportunities for fathers to attend, to learn from, and to effectively continue at home their children's early intervention program, the positive effects of such factors as direct modeling as reported by Hendrickson and Hester (1977), careful structuring as reported by Cartwright (1981) and Casto and Mastropieri (1986), and written handouts as reported by Lewis (1984) and Moxley-Haegert and Serbin (1983) were all substantiated by this successful practicum. Probably the the most important factor in the successful inclusion of fathers was flexibility of the professional. The therapist scheduled the appointments at the father's convenience as to time and place. This entailed evening and weekend implementation, primarily in the child's home. The importance of flexible scheduling for parent participation has been reported previously by Stile, Cole and Garner (1979), Tarran (1981) and Ferholt and Gurwitt (1982). However, once the initial contact was established with the father at his convenience, he was more apt to request that

therapy sessions be held on his day off and/or make greater effort to attend and participate in as many sessions as possible even though they were not scheduled primarily for his convenience. For example, several construction workers continued to attend and participate in morning physical therapy sessions on their rain days off after the implementation ended. They had not previously done so. Four of the fathers continue to attend and participate regularly in the sessions, which are now held during weekday mornings. Four other fathers have expressed continued interest and attend if possible. Therefore, if the professional can be flexible initially, especially when first scheduling very young children, to include father in the home implementation, father participation at more regular times would be increased, according to these findings.

Recommendations

1. Inclusion of father in physical therapy early intervention programs. This entails flexible scheduling to accommodate father, at least initially, demonstration followed by father-child practice with the exercise activities, and sensitivity to the vulnerability and needs of the father.

2. Frequent direct contact between the physical therapist and the father to ensure continuation of the home program. In this practicum, most fathers complied well with exercise implementation for two to four weeks. A recheck appointment at that time might have motivated continued programming. Von Wendt et al. (1984) reported that the reason

reported by the greatest number of parents for problems with the home program was "infrequent contact with physiotherapist."

3. Continued implementation by this therapist of the strategies for maximizing both parents' participation in effectively learning a home exercise program as well as the techniques to maximize father's active participation in a dyad with his child. This recommendation has begun, in fact, and is continuing to be effective.

4. Increased awareness by professionals of the importance of and opportunities for including both parents in the actual physical implementation of early intervention.

Dissemination

Dissemination of the results of the practicum has already begun. The author discussed the practicum and the importance of father-child interaction at a recent ASCP parent meeting (see Appendix H). Five families were represented and included four fathers and four mothers. Appropriate handouts on fathering were distributed. The author plans to submit a proposal for presenting at the Council for Exceptional Children's 65th Annual Convention in April, 1987. It is also planned to submit a paper to a pediatric physical therapy journal concerning effective methods of early intervention to help change if possible the outdated models of service delivery currently being used, according to Redditi (1983).

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APPENDIX A

CASELOAD TALLY SHEET

CASELOAD TALLY SHEET
(was given to home trainees at ARC 7/8/85)

Statistics		Father Participation			
...ts Name & Birthdate	Is Single Mother	By Mother's Report in home program	On Intake?	# Times Father participated / Total Visits	Has Father expressed interest

APPENDIX B

MEASUREMENT TOOL

YOUR NAME_____ TODAY'S DATE_____

YOUR CHILD'S NAME_____

Please circle the one best answer <u>for you</u>.

1. It's best to carry my child this way:

- OR -

- OR - DON'T KNOW

2. It's best to feed my child this way:

- OR -

- OR - DON'T KNOW

3. My child's leg muscles are mostly:

HYPOTONIC (TOO LOOSE) HYPERTONIC (TOO TIGHT) DON'T KNOW

4. For quality movement development, all children need to learn to:

ROLL SEGMENTALLY CREEP ON HANDS AND KNEES BOTH ROLL AND CREEP DON'T KNOW

5. My child has too much:

MOBILITY (MOVEMENT) STABILITY (STIFFNESS) DON'T KNOW

6. This activity → → for <u>my</u> child is:

GOOD NOT GOOD DON'T KNOW

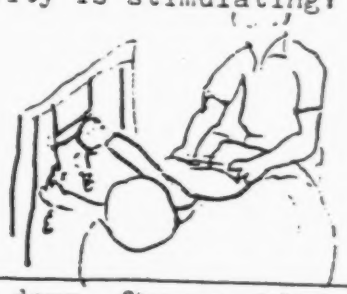
7. Prone positioning, for <u>my</u> child is:

GOOD

NOT GOOD

DON'T KNOW

8. This ball activity is stimulating:



PRIMITIVE POSTURAL REFLEXES

RIGHTING REACTIONS

EQUILIBRIUM REACTIONS

DON'T KNOW

9. Bouncing up and down, for my child, is:

GOOD

NOT GOOD

DON'T KNOW

10. My child needs to learn to sit like this:

- OR -

- OR -

- OR -

DON'T KNOW

APPENDIX C

DAILY DATA SHEET

DAILY DATA SHEET.

STUDENT'S NAME _____

FATHER'S NAME _____

PHYSICAL PLAY GAME(S) _____

GAMES: 1.
2.
3.
4.
5.

DATE	EXERCISE GAMES DONE TODAY	INITIAL WHEN DONE	COMMENTS

APPENDIX D

INTERVIEW QUESTION FORMS

Date 1st Session:
D.t. 2nd Session:

INTERVIEW QUESTIONS - PRETEST APPOINTMENT

Do you hesitate to feed, dress, or carry your child for fear that you might hurt him/her?

Do you enjoy playing with your child? Why or why not?

Do you think that your child likes to play with you? Why or why not?

Does your child let you know his needs, feelings, and wants? How?

Do you think your child needs you? In what way?

Can you see changes in your child? What kind of changes?

	Approx # of times/workday		times/day off	
	1st Session	2nd Session	1st Session	2nd Session
Feed eal your child?				
Change ange child's diapers?				
Dress or undress your child?				
Talk to, Read to &/or indirectly interact with child?				
ing, Move, Play with, /or directly interact with your child?				
ength of time you play th your child? (Approx)				

BEST COPY AVAILABLE

Interview Questions - Posttest Appointment - Father

1. Please give the approximate number of times/day: workday day off

   YOU feed your child_____

   change your child's diaper_____

   dress &/or undress your child_____

   talk, read, or indirectly interact with your child_____

   carry, move, play with or directly interact with your child(touch)_____

2. How much time/day do you play with your child on a regular basis?_____

3. Has the direct physical therapy contact made any change in either the amount of time or manner in which you interact with your child?

   _____

   _____

4. Has the assigned exercise series changed you or your child in any way?_____

   _____

5. Has this experience been of value for you or your child?_____

   How?_____

6. Which part was of the most benefit to you - the developmental information, the written exercise sheets, or the direct contact with the therapist?_____

   _____

7. Would you like to see direct physical therapy contact with Fathers and other family members continue?_____

   Why or why not?_____

   _____

Thank you for your participation.

APPENDIX E

HANDOUTS

A mother's cuddling won't fill the need for a father's attention; each parent brings different things to the child.

sumed for generations that babies responded primarily to their mothers; men were expected to bring home the paycheck and leave the child-rearing to their wives. Moreover, mothers were thought to play the vital role in their infants' development. Many studies in recent years, however, prove just the opposite: A new father's involvement with his baby is equally significant in the child's emotional development. Infants simply need both parents' attention. All the snuggling and cuddling a mother can do won't satisfy the baby's need for his father's attention, because each parent brings something different to the child. They don't compete, they complement each other.

"It's a question of acknowledging the differences between mothers and fathers, and the differences are good," says Dr. Michael Yogman, associate chief of the child development division at Boston's Children's Hospital. "There's no reason why a man can't change diapers, but that's very different from his expecting to be a mother. He should be himself, be a father. It'll come naturally to him in time. He just has to find his own little niche with his wife and baby."

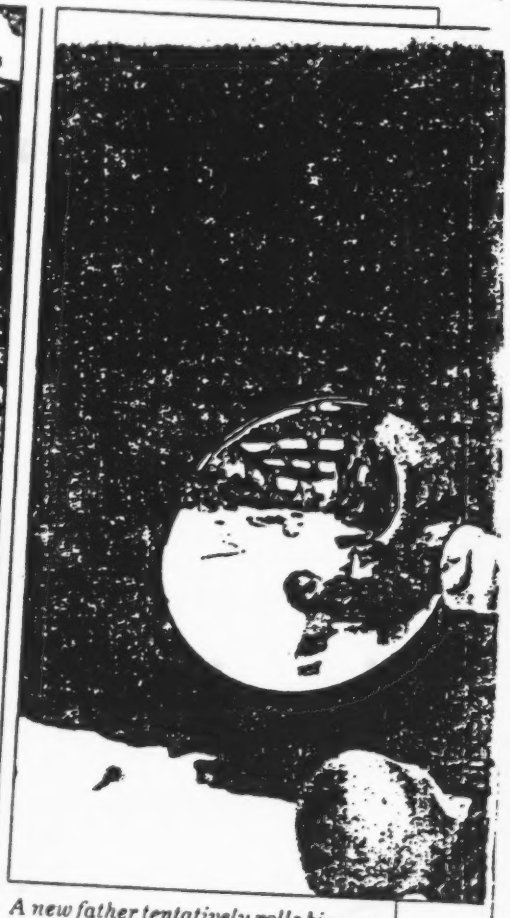
Karen Morgan, a registered nurse and the director of New York's Eastside Parent Center, agrees: "A new mother and father have to play off each other and understand that a baby is a new being about which a lot is unknown. A child should fit into your lifestyle and background; you needn't change those things for the child."

Sharing the Care: Who's on First?

The tremendous amount of work that's necessary during an infant's first few months of life can prove stressful for both parents. And as fathers grapple with the expanding definition of fatherhood, they face guilt brought on by the realization that it's not fair for their wives to carry the entire burden of early infant care.

It's easy to see that the whole family will benefit when both mother and father share that burden, but deciding *how* to split up the responsibilities may seem as perplexing as a newborn's wordless cries. New fathers' questions reflect that confusion: Should I take time off from work? How much? When? Who should change the baby? Who should feed him? When do I have to get up in the middle of the night? Who deals with demanding friends and relatives? And what about the household chores? Do we split them?

Often the best way to handle such



A new father tentatively rolls his newborn back and forth on a partially deflated beach ball (above left), both to relieve the baby's gas pains and to entertain him, then tries his hand at feeding (below left).

problems is to use common sense—particularly since the baby's needs often won't wait until you've worked out the details. Daniel Gray and his wife, Pat, haggled over who would do what until they agreed that the parent who was holding the baby when he needed a feeding or a diaper change would handle those tasks. "Look upon it as a sharing process," advises Gray, "and work out whatever is comfortable for *both* of you."

The extent of a new father's involvement with his baby—and with the chores—is simply a personal choice, best made in consultation with the mother. Morgan, whose parent center, among its other services, offers a hotline to answer new parents' questions, says there's no magic percentage, no right or wrong way to get involved. "Being a new father is not something you're judged on," she says. "People aren't giving you grades on your performance. It's common for a father to be a little uncomfortable with certain tasks, and he shouldn't feel that he has to change *all* the diapers.

"Begin by helping in an indirect way—it's all the same, and your wife will still benefit," suggests Morgan. "Help with the laundry or do the shopping or cooking if you can't stand dirty diapers. Play with your baby. Just think of yourself as a helper, a person trying to help someone you care about."

Supporting the Family Emotionally

Emotions run high in any household immediately after a birth, and they're not always joyous ones. Turmoil, anxiety, lack of sleep, and frayed nerves often mark the first few weeks while parents sort out the new routines of life with a baby. That's where new fathers come in handy, says Jeanne Watson of St. John's Hospital: "Emotional support from the father is really important in the first couple of weeks, because the mother will tire easily and may feel a little overwhelmed."

One potential source of stress for the new parents is the steady flow of friends and relatives who visit during the early weeks. Fathers who've been through the post-birth barrage of visitors say that relatives can be invaluable sources of information—and can try to take over the household, too. Their advice: establish clear guidelines for guests and remember who's in charge.

"If you let relatives come in, let them help out mostly with the housework," recommends first time father Tony Lowgood of Indianapolis, whose daughter, Elizabeth, was born in August. "Leave the parenting to the parents," he suggests. Relatives from another generation may have entirely different ideas about what constitutes good infant care, which can create unnecessary conflict at a time when family unity is essential.

Rick Bell, co-director of the St. Paul infant-care class, endorses those sentiments. His mother-in-law was not shy about expressing her negative opinions about breastfeeding to her daughter. "My wife needed constant reassurance from me that she was doing the right thing in nursing the baby," Bell recalls.

"My husband, Steve, would sidetrack my mother for me," says Donna Whitesell, an Indianapolis infant-care instructor. "Everybody wants to see a new baby. It's a good time for the father to step in and act as a diplomat." Paul Ebert, a new father who passes out little cards describing himself as "Mr. Mom," thinks that the father's role more often resembles that of a policeman. "Friends can definitely get in the way," he says. "The week after my daughter, Ann, was born, the house was full all the time. I had to control the traffic so my wife could rest."

Using a mirror to capture his baby's attention (above), hoisting him into the air (right), and giving the infant a closeup view of two familiar faces (far right) are some of the ways a father can engage his newborn in play.

Fear and Loathing At the Changing Table

Once new parents settle into a routine of shared responsibilities, fathers who have taken on basic-care duties such as diapering, feeding, and soothing their babies may find themselves stymied by fear or frustration or both.

"'What do I do? How do I do it? I don't know anything about it!'" says child-development specialist Yogman, voicing new fathers' first reactions to baby care. "Fathers aren't that much different from mothers," he says. "Mothers don't know what to do until they try, either."

Yogman suggests that much of the fear new fathers feel comes from the high standards—real or imagined—that they set for themselves. "Men have a real longing to be involved with their children from the beginning, but many of them are afraid," he notes. "It's important not to feel you have to be the 'perfect father' but to loosen up, have fun. Watch the baby's responses—he will encourage you."

New fathers agree that the baby makes even that first awkward diaper change worthwhile. Although their fear of mistakes prompts many fathers to compare the experience to parachuting from an airplane, they say that the fears do subside once that cautious first step is taken. "I always thought that changing diapers was a necessary evil. But the more I do it, the more I like it, because my son seems to really respond when I help him," explains one first-time father. "He really seems to like it when I change his diapers."

Just as unnerving as apprehension are anger and frustration and the guilt that follows them. Tony Lew good wanted to help his wife as much as possible, but the necessity of getting up and going to work each morning tempered his eagerness to be part of late night feedings. "I was sitting up at 3 a.m. rocking Elizabeth, trying to get her to stop crying," he remembers. "I was frustrated, thinking how tired I would be the next day if she didn't go to sleep pretty soon. At one point she just looked right up at me as if she knew what I was thinking, and that made me feel guilty as hell." Tony finally settled on Friday and Saturday as his time to feed the baby during the night. That gave his wife at least two successive nights of sleep while eliminating his worries about his work schedule.

Another frustration arises for husbands of breastfeeding mothers, not only because they can't help with the feedings, but also because they feel guilty for sleeping while their wives nurse every few hours during the night. And the frustration isn't solely the fathers': Marty Margolieus of St. Paul says his wife, Lisa, grew more short-tempered and irritable during night feedings because he'd go right back to sleep.

"She never got any sleep, and I did," he says. "It caused tension; she resented me because I slept through the feedings, and I found that my patience wasn't as strong as I'd thought it was." His solution was to get out of bed when the baby cried at night, change her diaper, and bring her to Lisa for a feeding. By contributing to the process, he provided crucial moral support and eased his wife's feeling that she had to do everything by herself.

Many new fathers, overwhelmed by the emotions and responsibilities of caring for a newborn, forget that there's an important payment for all that work: babies, in spite of all their demands, give their fathers an enormous amount of love. "The crying drove me crazy," says one father, "but after a couple of weeks I found out how nice it is to have a kid. The real joy she brought into our lives was the biggest surprise." ■

Crib Notes For New Dads

Some men shy away from even the most basic baby care; they worry that the baby might break in their hands or, worse, deflate if accidentally poked with a pin. But their biggest fear is admitting those worries—and asking for advice. No one, they claim, has ever heard a new mother ask how to pin a diaper or bathe a baby. Myths and misgivings aside, however, the truth is that no one instinctively knows just how to take care of a baby and that most of the basic skills are no harder to learn for a man than for a woman.

To help you master the fundamentals of fathering, here are some simple directions:

Safety: Whether you're changing, dressing, bathing, or playing with the baby, never leave him alone, even for a moment. Don't smoke while holding or playing with him, either. Keep sharp or shiny objects, particularly pins and buttons, away from his reach; they can cause serious internal damage if accidentally swallowed. Use an infant seat with restraint belts whenever you take the baby out in the car.

Diapering: Your baby will require about 4,000 diaper changes in the course of his first year, so you'll have plenty of chances to practice. Again, have all the equipment ready: disposable wipes, oil or lotion, a clean diaper, and a diaper pail. Remove and dispose of the soiled diaper. Thoroughly clean the genital area with a disposable wipe, being careful with a girl to wipe toward her back, away from the vagina. Apply oil or lotion. If you're using a cloth diaper, fold it to form a triangle; place it beneath the baby with the center angle pointing toward the feet. Then bring the three points together and secure with a safety pin.

Dressing: Gather up the garment at its sides, pass it over the back of the baby's head, and slip it quickly over his face. Ease the garment over the baby's arms and legs; never force or push limbs into sleeves or legholes.

Burping: You can experiment with any of these three methods: (1) Lay the baby across your knees, face down, and gently rub his back. (2) Set him on your knee, using one hand to support his neck as he faces you and the other hand to rub his back. (3) Hold him to your shoulder; again, rub his back gently. If he hasn't burped after several minutes, give up. He may not need to.

Touching, Playing, and Singing: Crying babies can often be lulled to sleep by the sound of soft, steady music in the room or by the hum of a blow-dryer if music isn't available. Your singing voice may also have a calming effect on your child. Sing slow-paced songs to help him sleep. During play, use exaggerated facial expressions as you sing, and move the baby's arms and legs to the music.

For more intimate play, consider taking the baby into the shower or bath with you. It's wise to hand the baby to your wife before you step in or out of the tub or shower, though, rather than risk slipping on a wet floor. ■ —*B.S.*

Getting Over Bath Anxiety

Here's the best way to approach bathing your newborn:

For the first week or so after birth, wash the baby with a soft cloth or sponge and warm water. You can begin tub baths after the umbilical cord has dropped off and the navel has healed and, with a circumcised baby, after the circumcision has healed.

- **Gather all the equipment you'll need beforehand.**
- **Be sure the room is warm, and check the water temperature with your wrist or elbow; it should be warm, never hot.**
- **Pour three inches of warm water into a small tub. Use a soft cloth and plain water to wash the baby's face (top photo). (Don't attempt to clean his eyes, nose, or ears, however.)**
- **Shampoo the baby's head next; then use mild soap to wash his neck, chest, arms, stomach, and back (center photo).**
- **Wash the genital area using a front-to-back motion.**
- **Rinse well and dry the baby thoroughly with a soft cloth (bottom photo).**

Photographs by David Luttrell

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THE EARLY YEARS

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A LOVING DAD MAKES A HAPPY CHILD

Dr. Brazelton with his youngest son, Tony, in 1974.

Bringing up baby isn't just a mother's job anymore. Today's father is more important than ever. His special influence can make all the difference in the world to baby—and Mom, as well.

BY T. BERRY BRAZELTON, M.D.

It's still rare, in my practice, to see a father bring his infant in for a check-up. But when John and Carol had a daughter, Mindy, they decided that because of their career schedules, John would be the baby's primary caregiver. From the first, it was a pleasure to watch his gentleness toward his daughter. Early on, he had learned to anticipate Mindy's needs, and although Carol breast-fed the baby, John got her ready for feeding, burped her afterward and changed all the diapers. I marveled at his eager participation and also at Carol's ability to step back and allow him to take over. Never once did Carol tell John how he might have done something better or hesitate before handing Mindy to him. She knew better than to undermine her husband's confidence.

At Mindy's 2-year checkup, father and daughter sat across from me in the examining room while I asked John how things were going. "Okay," said John somewhat tentatively. Mindy and I both looked at him after this half-hearted reply. "Just okay?" I asked.

"Well," he began, "Mindy now calls me Mama-Daddy—Mama when she needs something and Daddy when she wants to play." I was impressed by Mindy's capacity to identify her needs for him—and the roles he filled—in such a clear and straightforward way. He blushed and said, "I know we're doing fine, but it's embarrassing when she calls me Mama in front of my friends." I was caught up short by the fact that this masculine father, who had been so truly involved in providing Mindy with a wonderful start in life, could still be vulnerable to his own image of what a man should be. I then realized how deeply the past—our own, and our society's—affects us.

I think of *my* father—a cheerful, generous man who saw his role as that of supplement to my mother's. He did with us what she told him to. He taught us sports and other typically "masculine" activities and enforced discipline when her strong limits weren't enough. During my adolescence, it pleased him when we talked "man to man," but we weren't comfortable together, even then. Neither of us knew much about the other, although I longed to know him better, and I'm certain he felt the same way about me. But both of us were controlled by the stereotypes of the times.

The role of father has undergone drastic changes in the years since I was a boy—with fathers today becoming more aware of the significance and joy of participating actively in their children's lives. Still, it may take a few more generations before men are truly able to get beyond the old stereotypes and feel totally comfortable with their nurturing roles. It seems important to me that as we struggle to understand a father's true function—and expand his involvement in child care—we understand also the ways in which father and mother differ.

Let's backtrack here, to the moment when a baby first arrives. We have two parents facing the enormous responsibility of providing the best environment they can for their new offspring. But what is "best"? Society's standards for parents aren't *(Continued on page 66)*

Contributing editor T. Berry Brazelton, M.D., is associate professor of pediatrics at Harvard Medical School and chief of the Child Development Unit at the Boston Children's Hospital Medical Center. He is the author of Infants and Mothers, Toddlers and Parents, On Becoming a Family *and* To Listen to a Child.

QUESTIONS FATHERS ASK

How soon can I start to get to know my baby? Before it's born. Knowing a baby is largely a matter of allowing yourself to be conscious of your own longing to be a nurturer.

If I become a nurturer, won't I be playing the "feminine" role? Each sex has a healthy mixture of feelings and behaviors that might be attributed to the other. It's time we discarded those stereotyped sex roles and learned to value our full potential.

Even if my wife and I share the child care, she's still the primary parent, isn't she? Fathers are important counterparts for both the child and the mother. A father plays a vital and unique role in the family if he's willing to develop it.

What if my wife resents my invading "her area"? It's entirely natural for you and your wife to feel competitive about the baby. This is a sign of caring intensely, not of anger with each other. In fact, competition can be a strong positive force in motivating parents to do their best for the baby, if they use it to sort out the jobs to be done.

Don't professionals who [illegible] involved with children—pediatricians, teachers, [illegible]—tend to ignore fathers? Fathers need to demonstrate that they *want* to be included in discussions about their children. Then their presence will be welcomed. Don't wait to be asked!

By allowing himself to know his *(Continued on page 67)*

bly share in that experience? I recommend that a supplementary bottle be started so that the father, too, can feed the baby. Given at the end of the day, or in the middle of the night, this feeding will give the mother a needed rest and the father a chance to get to know the baby all alone. Best of all, he will soon notice that the baby responds to him as an individual, distinct from the mother.

By the time a baby is 3 weeks old, he will have learned his father's voice and be able to differentiate it from the voice of another man. By 4 weeks of age, we can watch a baby, without knowing whom he's reacting to, and judge correctly, from his actions, whether he's interacting with his mother, his father or a stranger. With his father, his shoulders hunch, his eyebrows are raised, his mouth is open, his eyes become flashingly bright. Everything about him suggests that he's anticipating excitement and play.

This role of stimulating the baby for fun and adventure is a uniquely paternal contribution, as is the father's function in defining sex roles. Although a man may not think he feels any differently about a daughter from the way he feels about a son, his relationship with each is different from the beginning. Rather than worry about the fact that he is perhaps more physical with his son, more protective with his daughter, a father should realize that he is helping each child to learn about him- or herself.

For example, during the second year a boy will begin to emulate his father, pretending to shave or wear a tie or even walk "like Daddy does." From age 3, he'll begin to compete with Daddy for Mommy's attention. A girl will tend to be more flirtatious when Daddy's around, behaving in an exaggeratedly feminine way. At about 4, when she has learned how to successfully ignore Mommy's repeated orders to go to bed, she will become suddenly acquiescent and charm-

A LOVING DAD MAKES A HAPPY CHILD (FROM PAGE 64)

clear. So, for a new mother, often plagued by anxiety and feelings of isolation, the husband/father becomes a vital counterpart—a sounding board for her ideas and a source of new ones.

Recent studies point to substantial developmental gains in babies whose fathers participate in their care. Among school-age children whose fathers are actively involved, studies have shown higher I.Q. scores, as well as a better sense of humor, a longer attention span and more eagerness for learning.

How can a new mother encourage and reinforce a father's involvement? Ideally, the process begins even before the birth of a child. Some expectant fathers today may still need to be encouraged to be active participants in the birth process. Groups such as the Childbirth Education Association and Lamaze organizations have demonstrated that educating the husband during his wife's pregnancy leads to his participation at the time of labor and delivery.

There is no inherent inability on the part of men to care for babies. All a father needs is permission to learn his job. Men who have the chance to see and hold their babies right away become significantly more adept at responding to them, eagerly learning how to burp them, talk to them and dress them. I'd like to see all newborn nurseries include the father in their baby care demonstrations and allow him to experience all the wonderful things a newborn can do—turn toward the sound of his voice, follow his face with her eyes and cuddle into the corner of his neck, just as she does with her mother. The more of that sort of reinforcement a father receives, the more motivated he becomes to spend time with his baby.

But even when the father helps care for the baby, the question of breast feeding inevitably comes up. How can he [illegible]

Disney Characters © Walt Disney Productions. "Hagar's Ann" © 1982, 1984 Chance [illegible] Inc. PEANUTS Characters © 1950, 1958, 1963 United Feature Syndicate, Inc. [illegible] © 1985 Hanna-Barbera Productions, Inc. [illegible] Ned Flanders [illegible]

ing when Daddy says, "Okay, let *me* take you to bed." What more could any father need to underscore his critical role?

To a large extent, of course, it is the mother who determines how important the father's parenting role will be. Some mothers may be reluctant to relinquish control and preeminence in their child's life. But as long as a mother simply assigns her husband tasks, he won't achieve the kind of active and fruitful involvement that makes for the best fathering. Part of his role is to dilute the intensity of the mother-infant relationship, thus allowing the child to become more independent. Learning to sleep alone at night, learning to feed herself and to explore in her second year—all are made easier when a father is there to offer encouragement.

Some fathers resist parenting for fear that they'll "do it wrong." Learning to parent comes by making mistakes and learning from them, by trial and error. For a man who has learned to be a perfectionist in the workplace, learned *not* to make mistakes, fatherhood can be a frighteningly uncharted course. It may be hard to give up the conviction that there's more to a man's life than just being successful at work. But I see today's "new" two-income family as being made up of four parents (mother and father each split in two—half for the family and half for their jobs).

To meet these increased demands, fathers, especially, will need a lot of support. Fortunately, there are support groups for fathers springing up all over the U.S. I would urge any new father to look around for one nearby, via the local Childbirth Education Association. These groups offer real backup against the stress that's engendered whenever we assume greater responsibilities or give more fully of ourselves. For no matter how stressful the challenges may be, it's vitally important to our children that they have the benefit of active participation on the part of *both* parents.

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QUESTIONS FATHERS ASK *(from page 64)*

baby from the beginning, a father is giving himself a chance to understand his own feelings and discover how he can unfold as a person. Caring for a helpless newborn will increase his sense of being a good person.

What is a father's major function as far as his child is concerned? Fathers need to balance mothers in the area of fostering a child's independence. His presence is also needed at the end of the day when both mother and baby will welcome his fresh, untried ideas.

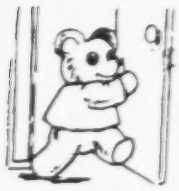
I want my kids to have a nonsexist upbringing, but I find it hard to treat my son and my daughter exactly alike. Let yourself love each child in the way you feel that love. You are an important model they both can learn from. A boy will learn about masculinity from you and emulate your behaviors. A girl will learn about men for her future. If you allow them to, they both will learn about the gentler, nurturing side that a man has to offer.

As my children get older, how can I be sure I'm really in touch with them? Designate a special time each week for each child to be alone with you. Even if you have family time every day—reading at bedtime or playing rough-and-tumble before dinner—arrange for one-to-one time, too. Then your children will have a chance to develop their own individual relationships with you. □

BOOKS FOR FURTHER READING

Fatherhood USA, by D. Klemmam & R. Kohl (Garland Publishing, 1984) *Fathers*, by R.D. Parke (Harvard University Press, 1981) *The Fathers' Almanac*, by S.A. Sullivan (Doubleday, 1980) *Who Will Raise the Children: New Options for Fathers (and Mothers)*, by J.A. Levine (Lippincott, 1976) ■

LEARNING . . . THE DISCOVERY PROCESS



How Does Your Child Learn?

- **BY USING THE SENSES:** Your child learns from everything around him/her. The child first learns about the environment through listening, looking, feeling, tasting, and touching. When given attention and gentle stimulation from people and objects, young children begin learning and developing.
- **BY EXPLORING:** During the early months of development, children first use their mouths for touching and feeling. Slowly they replace this with the use of their hands. Through movement, they actively explore and experiment with all things around them. They begin to notice differences in the way things sound, look, and feel.
- **BY PLAYING:** Children receive pleasure and satisfaction and are motivated to explore as they play and learn about themselves. They are able to practice activities such as manipulating objects and helping with household chores as well as expand their knowledge of textures, shapes, and functions of objects.
- **BY IMITATING:** Children learn many things by watching and copying others. They try out behaviors they have seen and pretend to be animals/people they know. Children tend to imitate actions of their parents if they see them running, drawing, hopping, or performing other various motor activities.
- **BY PRACTICING:** Children learn by doing activities over and over in all kinds of situations. Every time a child learns a new skill he/she tries it again in various positions and with different objects. For example, when learning the skill of emptying, you may find a child emptying everything in sight.

GETTING FROM HERE TO THERE . . . MOTOR DEVELOPMENT

The development of motor skills provides the basis from which sensorimotor, cognitive, language, and self-help skills evolve. Some motor involvement is found in every behavior that a child exhibits. Babies are born with reflexes, that is, automatic reactions which begin the interactive process with the environment. For example, an infant sucks when his/her lips are touched, turns his/her head when the cheek is stroked, moves the entire body in startled response to a loud noise, and grasps an object placed in his/her hand. These reflexes are the foundation on which more complex motor skills are built. Learning begins to take place as the infant touches, reaches for, mouths, and handles objects. Movement becomes more purposeful and goal directed. Thus, motor development is the result of physiological maturation and environmental learning, both of which are essential.

Motor development can be divided into gross motor and fine motor skills. Gross motor skills involve the use of large muscles for activities such as sitting, crawling, and walking. Fine motor skills involve the use of the small muscles for activities such as focusing and following an object with the eyes, holding and manipulating a spoon, buttoning a shirt, and drawing with a crayon. When examining motor development, there are several principles to consider:

1. Gross motor development proceeds from the head downward to the feet. A baby first learns to lift and turn his/her head. Then, more control and coordination of the shoulders occur followed by development of the trunk and control of the legs.
2. Fine motor development proceeds from the midline of the body to the fingers and toes. Thus, babies learn to focus and follow moving objects with their eyes before they can purposefully manipulate toys or pick up small objects with their fingertips.
3. Motor development occurs in a sequential manner. Each new skill is based on the skill that came before. For example, children bear weight before they can stand with support and finally stand alone. The rate of development of children varies, but the sequence of development remains fairly consistent.
4. Motor development sequences overlap. While children are mastering one skill, they are experimenting with components of a succeeding skill. Skill acquisition is a process of experimentation and practice.

5. Motor behavior is characterized by refinement of gross movement patterns into more directed, isolated movements. Infants' movements are at first general and massive but later become more controlled. For example, a child of two months old at play will thrust the arms in excitement, but by five or six months will purposefully reach toward a toy and grasp it.

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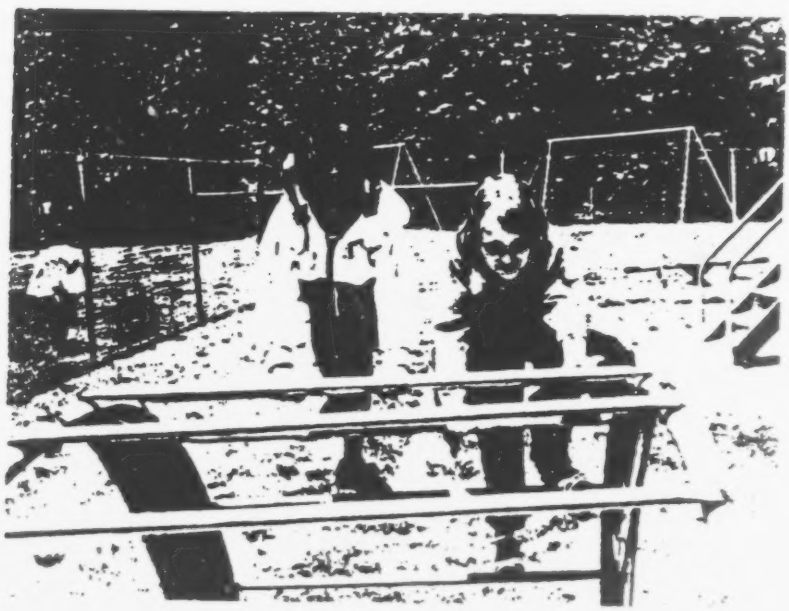
From early infancy, caregivers can foster motor development by providing varying experiences in which children can explore and learn about their world. In addition to providing a stimulating environment, it is very important to carry and place the baby in a variety of positions which encourage interaction with persons and objects. Good positioning enables the child to have a better view of the world. Changing the baby's position frequently provides new and interesting things for him/her to look at and encourages the baby to reach, touch, and explore. This exploration provides baby with more information about the world around him/her. Also, providing a variety of positions for short periods of time can help to strengthen a child's muscles. It is very important to check with your child's therapists to identify those positions which are most appropriate for your child.

3

As a child moves from infancy to toddlerhood, curiosity about the environment continues. With the skill of walking comes the ability to go after whatever attracts him/her. Encourage this curiosity since increased independence allows him/her to explore things of interest. The toddler seems to always be in motion making new and exciting discoveries. It's important for parents to show their pleasure and satisfaction as toddlers make new discoveries. Smiles and praise from parents encourage the child in this learning process.

The preschooler continues to have an endless need for experiences through movement and exploration. He/she runs, climbs, peddles a tricycle, builds with blocks, draws with crayons, and becomes more able to care for himself/herself.



Knowing the major milestones in development can help the parent understand the natural developmental sequence. However, keep in mind that children vary in the rate of their development, and growth may be somewhat slower in one area than in another. If you are concerned about your child's development, check with his/her physician, teacher, and/or therapists.

Through direct observation, knowledge of developmental sequence, and a great deal of patience, parents can effectively respond to the unique abilities of their child and create a stimulating environment for learning.

The following [illegible] provides a reference for the [illegible] motor and fine motor [illegible]

DEVELOPMENTAL MILESTONES

Fine Motor	Gross Motor

About 0-3 Months

- Uses eyes to follow an object moving slowly in the direction of up, down, and across
- Holds rattle briefly when placed in hand
- Watches movement of own hands
- Waves hands and kicks feet while lying on stomach
- Turns from side to back
- Turns head to either side when lying on stomach or back
- Holds head steady in upright position when being held above adult's shoulder

About 3-6 Months

- Holds hands together at midline
- Brings hands together at midline to hold an object
- Bangs objects in play
- Uses fingers and palm to grasp objects
- Pushes up from floor to bear weight on forearms
- Rolls from stomach to back
- Reaches for feet and brings to mouth
- Pushes self to a sitting position and sits alone momentarily

About 6-9 Months

- Uses raking motion to obtain an object
- Reaches for and obtains objects 10"-12" away
- Transfers objects from one hand to the other
- Claps hands
- Rotates wrist to manipulate toy or object
- Outstretches arms for protection when in a sitting or upside down position
- Crawls forward with stomach on floor
- Sits and reaches for toys
- Assists in pulling self to a standing position

About 9-12 Months

- Purposely releases an object
- Uses a neat pincer grasp
- Bangs spoon or cup
- Makes marks with crayon, pencil or paint
- Picks at objects with index finger
- Creeps forward on hands and knees
- Pulls self to a standing position using stable support
- Cruises holding onto furniture
- Walks with support
- Walks well without support and stands

DEVELOPMENTAL MILESTONES

Fine Motor	Gross Motor

About 12-18 Months

- Places cubes in a cup
- Holds crayon and scribbles on paper
- Stacks one block on top of another
- Builds tower of 3-4 cubes
- Places 1/4"pegs in board

- Creeps up steps
- Stands alone in the middle of the floor
- Creeps down steps backwards
- Rises to a standing position independently
- Kneels unassisted
- Walks alone

About 18-24 Months

- Imitates a vertical stroke using a crayon
- Places 3 shapes in a formboard
- Manipulates an object with fingers and thumb
- Turns pages of a book one by one

- Walks up and down steps with support
- Pushes/pulls a light object
- Runs length of the room without falling
- Picks up a toy from the floor while standing

About 24-36 Months

- Imitates drawing horizontal/vertical strokes
- Snips paper using blunt scissors
- Completes formboard of 5 or more pieces.
- Tries to button/unbutton large buttons

- Walks up and down steps holding the rail
- Kicks ball forward
- Throws ball overhand
- Balances momentarily on one foot
- Pedals a tricycle
- Runs without falling

About 36-48 Months

- Strings 1/2" beads
- Copies a circle
- Puts together objects requiring eye-hand coordination
- Snips along a straight 1/4" line with a continuous opening/closing motion

- Catches a bounced ball
- Walks up and down steps alternating feet without support
- Throws ball overhead
- Walks heel-toe along a straight line
- Stands momentarily on balance beam without assistance

About 48-60 Months

- Demonstrates hand preference
- Copies shapes (circle, square, triangle, rectangle) from an example
- Draws a stick figure
- Cuts out a circle and other simple shapes

- Gallops and skips while alternating feet
- Hops on one foot
- Catches a ball with both hands
- Jumps with both feet
- Kicks a ball forward at a target

DEVELOPMENTAL MILESTONES

Fine Motor	Gross Motor
About 60 + Months	
• Prints capital letters and simple words, some letter/word reversals are evident • Uses appropriate hand placement while cutting and writing • Prints numbers 1 to 5 • Laces own shoes	• Jumps rope • Roller skates • Hops 2-3 yards forward on each foot • Runs with arms swinging opposite to feet • Jumps on toes from a height of 12"

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early childhood education

a continuum
in child growth
and development

infancy — eight years

A CONTINUUM IN EARLY CHILDHOOD EDUCATION

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
DIVISION OF INSTRUCTION
1320 S. W. FOURTH STREET
FORT LAUDERDALE, FLORIDA 33310

DIVISION OF INSTRUCTION

Early Childhood Education

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PREFACE

This continuum is based upon the characteristics of children from infancy through eight years of age.

The characteristics or traits are not to be regarded as rigid norms but rather to be interpreted as illustrations of behavior which tend to occur at each particular age. The age levels indicated are a guide to identifying the maturity level at which the child is functioning.

Because each child has a unique growth pattern which is directly related to his learning process, curriculum experiences are carefully planned around the developmental levels.

ESEA - TITLE I
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MOTOR	Begins to develop muscle tone. Has incomplete head control. Averts head to preferred side. Has ability to extend one arm while other remains flexed. Hands are fisted.
VISUAL	Eyes roll less aimlessly. Is able to hold eyes in fixed position. Follows an object held directly before eyes for short time toward midline. Eyes take the lead in organization (reaches with eyes).
VERBAL	Expresses language by crying. Limits laryngeal vocabulary to a few throaty sounds.
SOCIAL	Is unable to cope with social stimulation. Subdues or brightens facial expression upon social approval. Sense of security is developing from calm and assured handling. Sensory-motor experiences are most important. Behavior patterns are undergoing organization and reorganization through immobilization as well as activity.
AUDITORY	Reacts to sudden noise.

Holds head upright. Rotates head freely from side to side. Fingers are nimble. Brings hands together. Puts hands into mouth. Clutches an object when it comes within reach.

Fixates eyes. Converges eyes upon a near object. Enjoys looking at strong reds and yellows.

Smiles at sight of face and objects. Bubbles, coos, gurgles and laughs.

Sensitive to cultural cues - expects routine. Demands more social attention. Differentiates between people.

Heeds the human voice.

MOTOR	Lifts head; balances head; grasps on sight; pulls. Uses hands for manipulation and exploitation. Uses thumb. Fine-finger coordination crude. Sits with slight support. Advanced neuro-muscular organization. Transfers objects from one hand to the other.
VISUAL	Discovers size, shape, weight, texture. Looks keenly at objects. Watches domestic routines with interest. Reads facial expressions, gestures, postural attitudes.
VERBAL	Vocalizes vowels and consonants in great varieties. Throat muscles are more highly organized. Vocalizes eagerness and impatience.
SOCIAL	Plays happily for short periods. Is self contained. Begins to build social perceptions about surroundings. Enjoys what people can do for him. Is sensitive to the environment in which he is placed.
AUDITORY	Enjoys rhythm. Responds to more than one person at a time.

Rolls over. Sits up. Pulls himself to standing position. Uses hand for locomotion. Uses index finger and thumb in opposition. Uses index finger to poke and probe. Enjoys gross-motor activity. Attempts throwing objects. Attempts to clap.

Begins to see and handle things in depth of perspective. Conscious of two as well as one. Perceives variations in detail. Shows interest in his own image in mirror.

Vocalization varied; says "ma ma", "da da". Enjoys making lip and tongue noises. Experiments with variety of pitches. Imitates sound.

Shows sensitivity to events. Responds to demonstration and teaching. Imitates gestures and facial expressions. Plays by himself for relatively long periods. Is shy with strangers. Cries for social attention.

Recognizes familiar sounds. Is afraid of a strange voice. Responds to his own name.

MOTOR	Attains a sitting position unaided. Prefers to creep. Pivots in standing position. Climbs. Sometimes walks on hands and soles rather than hands and knees. Feet become the fulcrum for freeing the hands. Is capable of finer coordination in eating and play activities. Grasps and lets go of objects. Walks with support. Picks up objects one by one, drops them and picks them up again.
VISUAL	Follows movements such as pedestrians, automobiles, and toys. Eye and hand begin to work together in locating and placing objects. Reacts to mirror image socially.
VERBAL	Is capable of communicative call rather than infantile cry. The call is a guttural "eh" or equivalent vocalization. Repeats familiar words. Is beginning to suit action to words. Tries to attract attention by a cough or sneeze if not by words.
SOCIAL	Shows growth in behavior patterns. Plays with several small objects rather than one. Voluntarily imitates and initiates actions. Enjoys an audience. Makes psychological distinction between himself and others. Displays primitive kinds of affection; jealousy, sympathy, anxiety.
AUDITORY	Begins to understand "no no". Listens with new intentness to words. Displays laughter or fear at unexpected sounds.

Achieves upright posture. Stands unaided. Walks alone. Makes strokes with crayon. Helps turn pages of a book. Has strong gross-motor drive. Is capable of starting, stopping, climbing, etc. Has power to release an object. Throwing is voluntary.

Is becoming aware of pictures in a book. Is sensitive to visual clues which have a social meaning.

Uses gesture language to call attention to discomfort, etc. Has more sophisticated interest in his own sounds. Communicates with himself as well as others through his jargon.

Wants to hold and carry things. Assumes a "me do it" attitude.

Sensitive to auditory clues which have a social meaning. Enjoys listening to music.

MOTOR	Exhibits locomotor drive; runs, goes up and down stairs with help; chases, pushes, pulls, walks backward. Is unable to turn corners. Walks on a broad base with feet apart. Runs with stiff, propulsive, flat gait. Uses whole arm movements. Hands not agile at the wrists. Coordinates hands and feet with difficulty. Takes off shoes, hat, mittens. Unzips a zipper. Sways to music with whole body. Enjoys tactile books. Shifts a paint brush from hand to hand.
VISUAL	Is satisfied with one color. Does a great deal of watching. Is learning by looking. Points to pictures in books. Looks for things in appropriate places. Discriminates quantitatively. Attracted to brightly colored books.
VERBAL	Has about twelve words at his command. Has abundant vocabulary of expressive gestures. Makes a vocal approach to his mirror image. Is beginning to substitute words for gestures. Jargon becomes more fluent. Has established favorite words such as "all gone" and "bye bye".
SOCIAL	Attends to the here and now. Has little perception for far-off objects. Has elementary insight into time and space. Has sense of "concluding". Thinks with his body rather than larnyx. Enjoys special toy or blanket. Knows where things go and where they belong. Shows correlation between temperament and social situations.
AUDITORY	Responds to a few simple verbal directions. Attempts singing by repetition of a single word. Hums spontaneously. Listens to short rhymes with interesting sounds. Has wide range in tone, pitch and intensity of voice.

Is more nimble at wrists. Turns pages of a book singly. Is sturdy on feet. Does not yet walk erectly. Knees and elbows are slightly bent. Goes up and down stairs without alternating feet. Kicks a ball. Rotates forearm, crudely imitates circular stroke. Muscles of jaw are coming under full voluntary control. Demonstrates a variety of strokes. Process is important to child. Construction portrays vertical and horizontal lines. Experiments with riding toys.

Muscles of eyes are becoming more adept. Is able to move eyes freely and is sensitive to peripheral fields.

Begins to put words together to form sentences. Is compelled to exercise vocal abilities. Vocabulary varies according to previous experiences. Linguistics apparatus (mouth, lips, tongue, larnyx and thorax) is undergoing rapid organization. Uses supplementary gestures to make clear meaning of new words. Has about 300 words in vocabulary. Sing songs his sentences. Is most fluent when telling his own experiences. Pronouns "mine", "me", "you", and "I" are dominant.

Watches rather than participates (pre-cooperative stage). Does not share. Demonstrates pride in ownership of toys. Prefers action toys. Is intrigued by water. Has genuine interest in mother-baby relationship.

Is able to sing phrases of songs though not on pitch.

MOTOR	Equilibrium is unstably balanced. Action system is a two-way system inviting such alternatives as yes/no, come/go, run/stop, give/take, grasp/release, etc. Is unable to make transitions easily. Suddenly shifts from intense activity to passive quiescence. Is interested in scissors but is unable to control them. Experiments with vertical and horizontal lines, dots, circular movements. Construction begins to show symmetry. Scribbles with crayons.
VISUAL	Pretends to pick up objects from picture. Enjoys looking at books alone. Enjoys watching things at a distance.
VERBAL	Play is accompanied by constant talking. Speech is uppermost in his mind. Makes definite requests. Spontaneous language is often rhythmical and repetitive. Names objects in a book. Begins to name simple structures. Reading in which he takes part is of interest.
SOCIAL	Entertains opposite alternatives but lacks facility in balancing them. Insists on certain routines. Wants to be with people but has difficulty coping with them. Uses imagination in play. Enjoys short excursions. Develops interest in animals, flowers, etc. Resists change. Displays extremes in behavior.
AUDITORY	Enjoys rhythm and repetition in rhymes and stories. Wants to hear elaborate details of his babyhood. Comprehension of verbal communication increases.

Is nimble on feet. Walks erectly. Turns sharp corners. Swings arms as he walks. Enjoys sedentary pastime which engages fine-motor coordination. Imitates drawing of cross. Buttons and unbuttons. Enjoys manipulation with hands; patting, squeezing, etc. Displays order and balance in building. Alternates feet when climbing stairs. Hops with both feet together. Is able to peddle a wheel toy. Enjoys tearing paper.

Distinguishes form. Small muscles of eye are more facile. Watches facial expressions. Reads facial expectations. Distinguishes between physical and personal objects. Becomes aware of and closely watches people at work and machinery that moves.

Repeats three digits. Vocabulary has increased to nearly 1,000 words. Verbalization accompanies dramatic play. Command of sentences is beginning to increase rapidly.

Tries to please and conform. Demonstrates three-step logic; counts to 3, names 3 pictures, shapes, etc. Is capable of sympathy. Waits his turn. Adjusts to social structure by shifting imaginary impersonations into play: doctor, mother, fireman, etc. Is capable of group play. Establishes social contacts. Dramatizes actions and words. Portrays some degree of self control. Is influenced in food and toy categories by radio and television.

Listens to words with increased assurance and insight. Has learned to listen to adults. Matches simple tones. Recognizes melodies. Listens to reasoning. Is attentive to the spoken word. Is intrigued by the phonetic novelty of new words.

MOTOR	Motor drive is high. Races up and down stairs. Throws overhead. Experiments with scissors. Laces shoes. Stands on one foot. Makes designs and crude letters. Draws objects with few details. Has little size or space relationship. Details which are most important to the child are portrayed largely in his picture. Constructs with wood, hammer and saw.
VISUAL	Attracted to a variety of books. Is becoming aware of symbolization. Enjoys looking at photographs which include self. Visual images in the mirror become important to dramatic play.
VERBAL	Likes different words, silly words. Questioning comes to a peak. Questions are not for pure pursuit of knowledge but devices for practicing speech. Wants command of conjunctions, adverbs and expletives. Adept at picking up phrases from his linguistic culture. Enjoys exaggerations. Delights in humorous stories. Responds to group singing. Increases in voice control. Words often outrun knowledge. Demands reasons with "why?" and "how?"
SOCIAL	Strives to identify himself with his culture. Desires social approval of peer group. Desires playmates. Develops strong sense of family and home. Tends to be bossy and domineering. Begins self criticism. Is cooperative and imaginative. Can work for a goal. Might have imaginary playmates. Chants in group activities. Is aware of a variety of textures. Tattling is frequent.
AUDITORY	Has high interest in rhyming poetry. Interested in sounds of instruments. Is aware of outdoor sounds. Likes to be read to. Listens more intently to tapes, records, television. Is developing favorite stories.

Drawing is spontaneous. Copies a triangle. Is eager to construct. Arms are held near body. Stance is narrow. Grasp and release are precise, direct and accurate in simple performances. Gross-motor activity is becoming well developed. Handedness becomes established. Initial approach is with dominant hand. Utilizes toys skillfully. Shows preference for small as well as large blocks. Rides, climbs, swings, jumps with ease. Shows interest in copying letters. Walks a straight line. Descends stairs with alternating gait.

Detects visual differences. Pretends to read. Counts objects. Identifies penny, nickel, dime. Begins to develop left-to-right eye movement. Signs are of particular interest.

Is learning names of things and actions, qualities, differences, and likenesses. Perceives opposites and analogies. Counts by rote. Talks constantly. Readily retells incidents but has difficulty retelling series of events. Expresses himself in correct finished sentences. Vocabulary has expanded to about 2,000 words. Interprets pictures.

Is fond of role playing. Easily becomes pilot, truck driver, etc. Is capable of self criticism. Has better defined self concept. Is ready for community experience. Is independent in everyday personal duties of dressing, washing, toileting, etc. Wants to go to school. Is proud of drawings. Distinguishes between truth and falsehood. Judgments are rather concrete but are laying the foundations for abstractions and generalizations. Plays predominantly on his own but likes to be in a group. Shows interest in completing a task. Begins to use a knife.

Assimilates meanings of countless words. Distinguishes similarities and differences in sound. Wants his own record player. Likes combination of music and words. Picks out tunes. Likes repetition.

MOTOR	May reverse letters and numerals. Drawings though crude are realistic. Consciously balances his body in space: climbs, crawls, falls, stumbles, etc. Is more aware of his hand as a tool. Although awkward in performing fine-motor tasks, he has a new demand for such activities. Wiggles in his chair. Touches, handles, explores materials. Makes crude structures with hammer, nails and saw.
VISUAL	Recognizes written words. Enjoys lotto games. Reverses words. Recognizes number symbols. Is likely to point with finger or bring head closer to book when reading. Distinguishes his own right from left hand but not in another person. Word attack skills begin to develop.
VERBAL	Is boisterous at play. Wants to spell. Substitutes words, reverses meanings and adds words. Frequently repeats a word encountered on the line above. Tends to subvocalize when beginning to read. Knows names of streets and location of major points of interest. Verbalizes during play. Likes group oral work: rhymes, jingles, songs, etc.
SOCIAL	Is aware of more than he can manage. Process is more important than product. Is aware of sequence. Is eager for more and more possessions. Likes to trade possessions. Apt to blame others for happenings. Better at winning than losing. Tells "tall tales". "Mine" is uppermost in his mind. Wants to "work". Is easily fatigued. Goes to extremes in behavior.
AUDITORY	Follows simple directions and rules. Enjoys stories, especially favorites. Begins to distinguish phonetic sounds. Tends to "do" rather than listen. Talks incessantly.

Uses voilent strokes with pencil. Erases frequently. Is cautious in approach to activity. Has new awareness for height. Repeats motor performance over and over until mastered. Pencils and erasers are important. Jabs pencils into eraser. Pencil grasp is tight but drops pencil often. Desires to write rather than print. May sit with head forward and tilted toward non-dominant side. May occlude one eye by dropping head down on one arm while writing or listening.

Is less distracted by peripheral movement. Is fond of more complicated table games. Reads to himself. Becomes more mechanical in his approach to reading. Can comprehend a story without knowing all the words. Uses word clues with competence. Observes carefully.

Depends upon verbal reminders. Talks in order to establish ranport and mobilize activities. Individual conversation develops. Uses language freely and adaptively. Hesitates on new words, makes vowel errors, guesses, omits and adds words. Substitutions of meanings are prevalent such as "a" for "the". Speed of reading shows individual variations. Enjoys naming initial consonants. Likes oral arithmetic.

Is sensitive to attitudes of others. Personality development is of great importance. Discriminates between "good" and "bad". Develops sense of ethics. Is aware of sun, moon, clouds, etc. Places more emphasis on time and space relationships. Shows an interest in causes and conditions. Sets high goals for himself but tends to be protective of himself if goals are not reached. Begins to take part as a real member of the family group. Desires to be a part of a social group.

Listens for long periods of time. Recognizes consonant sounds in isolation. Is more sensitive to variations in tone quality. Is able to recognize like phrases in melodies. Is becoming aware of vowel sounds. Identifies and reproduces rhyming elements.

MOTOR	Subtle changes in body proportions are taking place. Arms are becoming elongated. Hands are becoming enlarged which indicates pre-adolescence. Body movements are often graceful. Is aware of posture. Desires rough and tumble play. Becomes less fatigued. Accomplishes many feats such as skating and jumping rope. Is able to change posture quickly. Has more uniform alignment in handwriting.
VISUAL	Eyes accommodate far and near distances with increased speed. Is able to distinguish fundamental similarities and differences when comparing. Enjoys catalogues and encyclopedias. Is able to look before he acts but it is often with such speed that the pause is fleeting. Begins to draw in perspective. Drawings are likely to show action. Is becoming a good observer. Reads spontaneously. Is able to attack new words easily.
VERBAL	Converses with adults and peers. Loves to talk. Has highly exuberant speech. Enjoys superlatives. Verbalizes fear and may need encouragement.
SOCIAL	Has an outgoing positive contact with his environment. Appraises what happens. Is constantly redefining his status with elders and peer group. Shows susceptibility to jealousy. Is unable to grasp complex rules. Is building up a sense of ethics. Feelings are easily hurt. Readily takes part as a member of a small group such as the setting up of a lemonade stand. Begins to collect, store and hoard. Money, property and ownership are of importance. Is becoming aware of differentiations of sex. Has interest in babies, origin of life and marriage. Is able to be acceptive of different cultures. Is able to perceive implications and draw conclusions. Often has to be reminded to wash his hands (with soap). Is becoming more conscious of himself. Is aware of his looks as contrasted to others.
AUDITORY	Is conscious of tone of voice and its implications. Listens for suggestive clues in words that may give him an idea of what is expected. Often reacts negatively to reminders. Listens to the same program daily or weekly.

APPENDIX F

SAMPLE RESPONSES

~~YOUR NAME~~ Meghan Adams TODAY'S DATE 11/14/85

~~YOUR CHILD'S NAME~~ (F=Rick) missed 2

Please circle the one best answer for you.

1. It's best to carry my child this way:

– OR –

– OR – DON'T KNOW

2. It's best to feed my child this way:

– OR –

– OR – DON'T KNOW

3. My child's leg muscles are mostly:

HYPOTONIC (TOO LOOSE) HYPERTONIC (TOO TIGHT) DON'T KNOW

4. For quality ~~movement~~ development, all children need to learn to:

ROLL SEGMENTALLY CREEP ON HANDS AND KNEES BOTH ROLL AND CREEP DON'T KNOW

~~5~~ My child has too much:

MOBILITY (MOVEMENT) STABILITY (STIFFNESS) DON'T KNOW

6. This activity Ok later

~~for my~~ child is:

GOOD NOT GOOD DON'T KNOW

7. Prone positioning, for my child is:

GOOD

NOT GOOD

DON'T KNOW

8. This ball activity is stimulating:

PRIMITIVE POSTURAL REFLEXES

RIGHTING REACTIONS

EQUILIBRIUM REACTIONS

DON'T KNOW

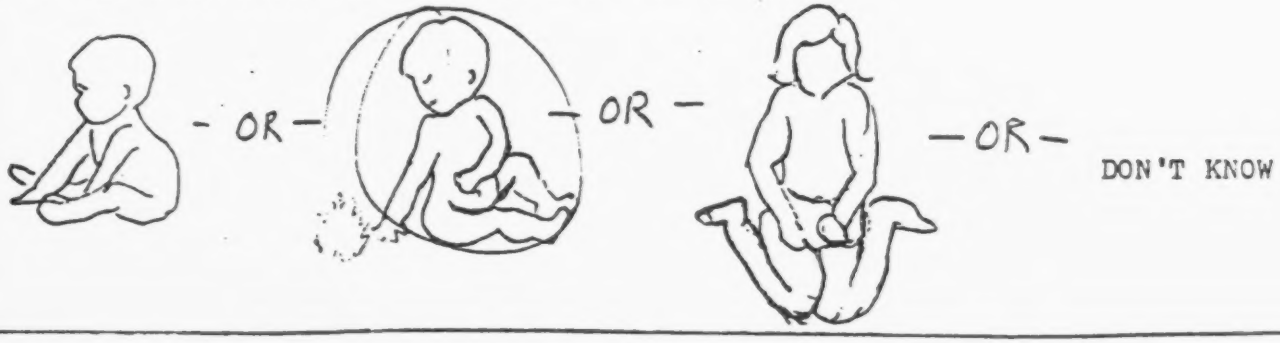
9. Bouncing up and down, for my child, is:

GOOD

NOT GOOD

DON'T KNOW

10. My child needs to learn to sit like this:



DON'T KNOW

all 5 sheets + data sheet
not all up there Richard.

Meghan Adams
Rick Adams -

Date: 1st Session: 11/14/85
2nd Session: 2/4/86

INTERVIEW QUESTIONS

Do you hesitate to feed, dress, or carry your child for fear that you might hurt him/her?

Do you enjoy playing with your child? Why or why not?

yes

Do you think that your child likes to play with you? Why or why not?

yes

Does your child let you know his needs, feelings, and wants? How?

yes

Do you think your child needs you? In what way?

Can you see changes in your child? What kind of changes?

	Approx # of times/workday		times/day off	
	1st Session	2nd Session	1st Session	2nd Session
ed your child?	wife day care		wife does care primarily	
ge child's diapers?				
ress or undress your child?				
lk to, React to &/or indirectly interact with child?				
ay, Move, Play with, &/or directly interact with your child?	Supper until bed = Dad		↑ on weekends 2-3 hrs + more on weekends	
ength of time you play ith your child?	2 hrs PM			

DAILY DATA SHEET.

STUDENT'S NAME Megan Adams #4 106

FATHER'S NAME Rick Adams #4

PHYSICAL PLAY GAME(S) Date given 11/14/85 Reckd 2/4/86

GAMES: 1. Rock on hands & knees
2. Sitting [illegible] rotating around & playing at table.
3. pull to [illegible] & dance
4. little rabbit jumps & dance (rotate) in standing
5. Cruise along furniture

DATE	EXERCISE GAMES DONE TODAY	INITIAL WHEN DONE	COMMENTS
2-9-85	Rock on hands & knees	RSA	[illegible]
	pull to [illegible]	RSA	[illegible]
			SHE PLAYS WITH TOY WHILE STANDING & BENDING AGAINST TABLE. GOOD BALANCE & CONTROL STILL DROPS DOWN TO FLOOR ON BUTT. DIFFICULT TO SHOW & WILL NOT COOPERATE!
	CRUISE ALONG FURNITURE	RSA	WILL CRUISE ALONG FURNITURE VERY SLOWLY USING A TOY ONLY.

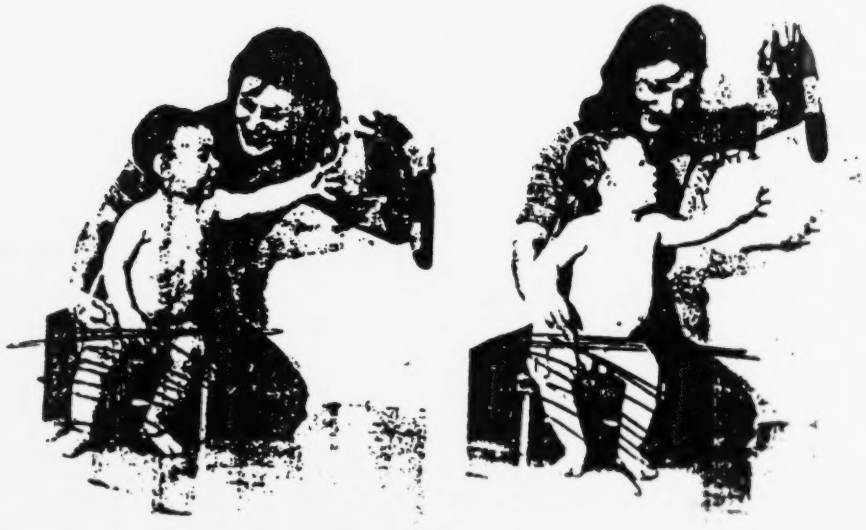
Repeatedly - contd doing ex's - verified by wife, mother & PT - (called for clarification) & PM but just stopped documenting during Holidays when routine was off schedule.

a. When the child is on all-fours, push her gently from side to side. First, push her at the shoulders, then at the hips.

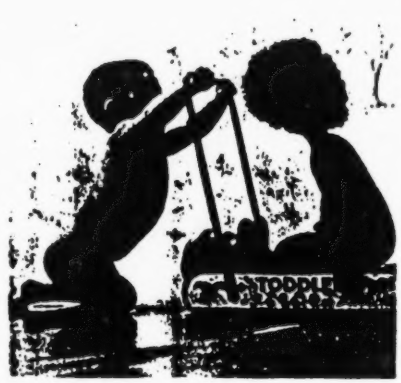
b. Position the child on all-fours on a balance board, water bed, or air bed. Tilt her from side to side to stimulate balance reactions.

2b

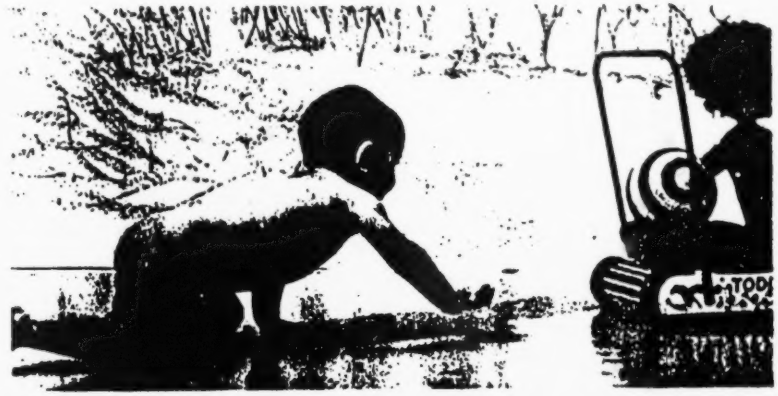
Position: The child should be seated on the stool with his feet on the ground, ankles at right angles to the feet, knees at right angles to the thighs, hips at right angles to the trunk.



ı all fours/standing

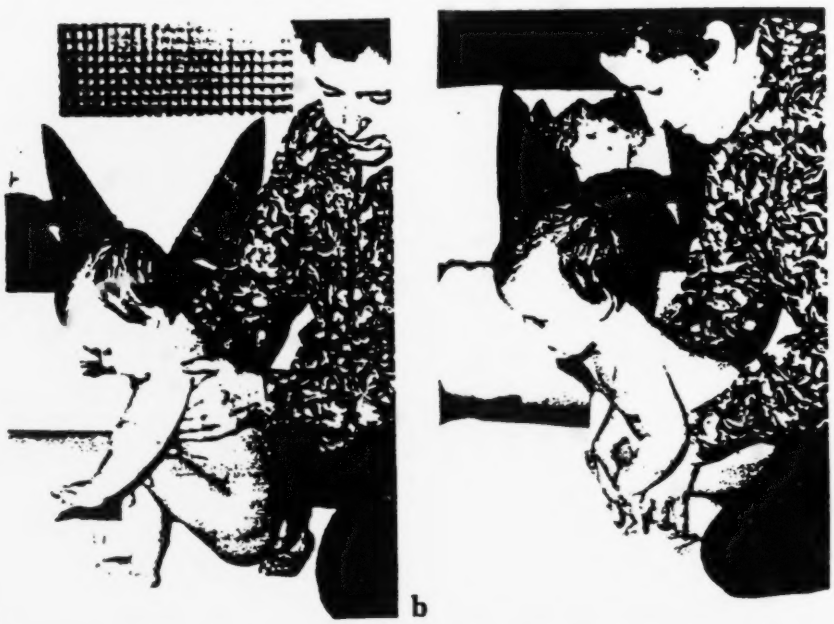


Position: Child on all fours. He will stand up with the help c the baby-walker.



100 **little rabbit**
crouching/standing

Position: The child sitting on his heels, the upper part of his body erect.



a b

Put one of his legs forward, feet flat on the ground, while holding him under his arms **(a)**. Bring the other leg up, feet flat on the ground: the child is now in a crouching position. Move him like a seesaw from back to front **(b)**. One day he will stand on his feet **(c)**.

st step

ıen the child first stands up, leave him to the pleasure of
; new sensation. Hold him either by the pelvis or by the
ıs. Make him turn the upper part of his body to one side,
the other, feet flat on the ground, body leaning slightly

forward. You must feel that the child has understood his
discovery and familiarized himself with this new skill.
Often, in the moment that follows this discovery, the ch
supported in this way takes his first step.

3. THE CHILD DOES NOT ATTEMPT CRUISING (ASSISTED WALKING TO THE SIDE).

a. Place the child standing at one end of the couch and put interesting toys at the other end. Encourage her to come after them.

b. Hold the child at her hips. Pull her hips in the direction you want her to step. Help her bring one leg toward the other one.

c. Assist the child in sideways walking along a hallway. Have her leaning onto her hands rather than grabbing something with them. This requires more strength and balance from her trunk and legs.

3a

3b

3c

Post test

YOUR NAME Rick Adams TODAY'S DATE 2/4/86

YOUR CHILD'S NAME Meghan Adams married

Please circle the one best answer for you.

1. It's best to carry my child this way:

- OR -

- OR - DON'T KNOW

2. It's best to feed my child this way:

- OR -

- OR - DON'T KNOW

3. My child's leg muscles are mostly:

(HYPOTONIC (TOO LOOSE)) HYPERTONIC (TOO TIGHT) DON'T KNOW

4. For quality movement development, all children need to learn to:

(ROLL SEGMENTALLY) CREEP ON HANDS AND KNEES BOTH ROLL AND CREEP DON'T KNOW

5. My child has too much:

(MOBILITY (MOVEMENT)) STABILITY (STIFFNESS) DON'T KNOW

6. This activity → for my child is:

GOOD (NOT GOOD) DON'T KNOW

7. Prone positioning, for my child is:

(GOOD)

NOT GOOD

DON'T KNOW

8. This ball activity is stimulating:

PRIMITIVE POSTURAL REFLEXES

RIGHTING REACTIONS

EQUILIBRIUM REACTIONS

DON'T KNOW

9. Bouncing up and down, for my child, is:

GOOD

NOT GOOD

DON'T KNOW

10. My child needs to learn to sit like this:

- OR -

- OR -

- OR -

DON'T KNOW

ERIK ADAMS 2/56

DAUGHTER - MEGHAN 15 MOS. CID

115

Interview Questions - Posttest Appointment - Father

1. Please give the approximate number of times/day: workday day off

	workday	day off
YOU feed your child	0	0
change your child's diaper	0	1
dress &/or undress your child	0	1
talk, read, or indirectly interact with your child	3	6
carry, move, play with or directly interact with your child(touch)	4	7

2. How much time/day do you play with your child on a regular basis? 2 HRS 4-6 HRS

3. Has the direct physical therapy contact made any change in either the amount of time or manner in which you interact with your child?
YES

4. Has the assigned exercise ~~series changed~~ you or your child in any way? YES

5. Has this experience been of value for you or your child?
How? Yes, my understanding of my child's development

6. Which part was of the most benefit to you - the developmental information, the written exercise sheets, or the direct contact with the therapist? Direct contact with Therapist best rewarding

7. Would you like to see direct physical therapy contact with Fathers and other family members continue?
Why or why not? Absolutely, direct contact with physical therapist answers all questions and a much better understanding of all the diseases involved.

Thank you for your participation.

APPENDIX G

COMPOSITE INTERVIEW RESULTS

COMPOSITE RESULTS
N = 9

Interview Questions - Posttest Appointment - Father

1. Please give the approximate number of times/day: workday day off

   YOU feed your child ___ answers range from "rarely" to 1/d

   change your child's diaper 0-1 max 0-1 max

   dress &/or undress your child ___ nonspecific answers like "often," "everyday," "frequently"

   talk, read, or indirectly interact with your child ___

   carry, move, play with or directly interact with your child(touch) ___

2. How much time/day do you play with your child on a regular basis? 1-3 hours 2-5 hours

3. Has the direct physical therapy contact made any change in either the amount of time or manner in which you interact with your child?
   8 = yes (manner = 4)
   (time = 2)
   1 = no, do not have time to spend with child

4. Has the assigned exercise series changed you or your child in any way? 8 = yes (child = 5, increased time together = 1, given us direction = 2); 1 = no

5. Has this experience been of value for you or your child? ___
   How? Both = 4, child = 3, me = 4 (developed a routine (goals) for us, understanding and awareness)

6. Which part was of the most benefit to you - the developmental information, the written exercise sheets, or the direct contact with the therapist? 9 = direct contact with the therapist
   2 = developmental information

7. Would you like to see direct physical therapy contact with Fathers and other family members continue? 9 = yes
   Why or why not? Clarifies developmental questions = 3
   Better understanding of need for and importance of exercising = 5; gives encouragement and structure for family involvement = 4

Thank you for your participation.

APPENDIX H

PARENT MEETING ANNOUNCEMENT

TAKE NOTE...

WHAT: PRE-SCHOOL PARENT MEETING

WHEN: THURSDAY JANUARY 16TH 7:30P.M.

WHERE: MAIN CENTER (BABY SITTER PROVIDED)

WHO: BETSY REVELJ, PHYSICAL THERAPIST

WHY:

It's a New Year! Lets get off to a Great Start. We really encourage you to attend the Parent meetings once a month. These meetings are informative and provide the opportunity for you to share concerns or information with other parents. This month our Speaker will be Betsy, the Physical Therapists. She will be talking about your children. She will giving very helpful hints on ways you may help your child, thru positioning, equipment, exercises, etc. She's an excellent Therapist and an interesting Speaker. Do plan to attend.

Sincerely,

Shirley Hoffman
Director Social Services